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ABSTRACT

Factors of success associated with eight medical school recipients of Financial Distress Grants from the Health Resources Administration were studied. "Factors of success" refers to the effectiveness of actions taken by the medical schools to improve their financial stability. (One school used the funds to maintain accreditation.) The nine medical schools receiving these grants between 1972-76 (one school was excluded from analysis because it is still receiving funding) are: Creighton University, George Washington University, Georgetown University, Meharry Medical College, New York Medical College, St. Louis University, Temple University, Tulane University, and the University of Nevada-Reno. The legislative background of the Financial Distress Grant Program is reviewed, and case studies are presented on each of the eight medical schools that were evaluated. To ensure anonymity, the schools are coded with letters. The actions that were instituted most often by the eight schools are identified. Revenue-producing actions were more commonly employed and had more impact on the financial performance of the schools than did cost-control measures. The actions taken by the medical schools were assessed as having either a major, moderate, minor, or no impact. At all of the eight schools, increases in tuition provided a major contribution to the operating budget of the school. Plans to increase the income provided to the school were a major and controllable funding source for six of the medical schools. The 10 actions that were most commonly taken or that had the greatest impact on financial performance are discussed individually, and charts that compare the actions taken by the schools (coded to ensure anonymity) and the impact of the actions are included. (SW)

A REPORT ON
MEDICAL SCHOOL RECIPIENTS OF
FINANCIAL DISTRESS GRANTS

FINAL REPORT

November 1980

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
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Management Consultants

HEALTH RESOURCES ADMINISTRATION
A REPORT ON MEDICAL SCHOOL RECIPIENTS
OF FINANCIAL DISTRESS GRANTS

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I - INTRODUCTION

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This introductory chapter describes the objective and scope of the study of medical school recipients of Financial Distress Grants, outlines the approach taken to it, and sets forth the arrangement of this report.

STUDY OBJECTIVE AND SCOPE

The objective of this study was to identify and analyze the "factors of success" associated with eight medical school recipients of Financial Distress Grants. "Factors of success" refer to actions proposed and taken by the medical schools as grant recipients, and the extent to which these actions were successful in contributing to the financial stability of the schools.

The scope of the study encompassed eight of the nine medical schools that received Financial Distress Grants between 1972 and 1976. The ninth school has been excluded from the study because it is still receiving funding. This study also focuses on the actions taken by the eight medical schools, rather than on the strategy or rationale used by each school in seeking and allocating the funds it received.

STUDY APPROACH

The study approach consisted of the following steps:

- Assembling and reviewing background data, including relevant legislation, regulation, and grant applications
- Interviewing selected persons at the Health Resources Administration, including those directly involved in administering the grant program
- Reviewing the specific objectives and actions cited by the medical schools in their grant applications

- Conducting site interviews with representatives at each of the medical schools and reviewing relevant data and information
- Analyzing the information obtained and determining each school's success in achieving its stated objectives
- Identifying and analyzing the "successful" actions common among the schools
- Developing conclusions and implications concerning the Financial Distress Grant Program
- Preparing a final report to document study findings.

ARRANGEMENT OF THIS REPORT

This report is arranged in five chapters, as follows:

- I - Introduction - (this chapter).
- II - Background - presents an overview of the Financial Distress Grant Program.
- III - Assessment Of Success Of The Individual Schools - presents case studies on each of the medical schools that received Financial Distress Grants, including discussions on each school's background, its objectives in seeking the grant(s), actions taken by the school to improve its position, and a summary of its success in achieving its objectives.
- IV - Assessment Of The Actions Taken - discusses the impact and extent of commonality among the actions taken by the medical schools.
- V - Other Conclusions And Next Steps - describes other conclusions derived from this study and suggests the next steps to be taken.

II - BACKGROUND

This chapter describes the principal characteristics of the Financial Distress Grant Program, and discusses its legislative background.

DEFINITION OF FINANCIAL DISTRESS

"Financial distress" is defined under Section 773(a) of the Public Health Service Act, as amended by the Comprehensive Health Manpower Training Act of 1971. Under this act, an eligible school may be considered to be in financial distress if it is in "serious financial straits" to meet its operating costs or has "a special need for financial assistance" to meet accreditation requirements.

The legislation was subsequently replaced by the Health Professions Educational Assistance Act of 1976. Under Section 788(b) of the act, the definition was broadened and sharpened. An eligible school may be considered in financial distress if it has an operating income insufficient to meet the costs of operation in the fiscal year for which the grant is sought, a special need for financial assistance to meet accreditation requirements, or a need for financial assistance to implement operational, managerial, and financial reforms.

NATURE AND SCOPE OF THE PROGRAM

The Financial Distress Grant Program has been available to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry or public health. Schools requesting the grants were required to submit a detailed, formal application in each year that funding was sought. The application format required a discussion of the extent of the problem, the sources and causes, the actions already taken, and the plan proposed to eliminate financial distress.

II - BACKGROUND

From fiscal 1972 through 1980, approximately \$64 million in grants were approved. As shown in the table below, more than half of the funds awarded under this program went to medical schools:

<u>Type Of Schools</u>	<u>Number Of Schools Involved</u>	<u>Total Volume Of Grant Support (Millions)</u>
Medicine	9	\$33.4
Dentistry	10	18.5
Podiatry	4	3.5
Pharmacy	3	3.6
Veterinary Medicine	2	3.3
Optometry	2	0.9
Osteopathy	2	0.8
Total	32	\$64.0

The total volume of grant support awarded to medical schools was highest during the first three years of the program (1972, 1973 and 1974). In fiscal 1972, a total of \$6.6 million was awarded to six medical schools. During 1974, funding totalled \$7.4 million for eight schools of medicine. Since 1977, by contrast, only one medical school has received Financial Distress Grants. The grants awarded from fiscal 1972 through 1980 are summarized in the following table:

<u>Fiscal Year</u>	<u>Number Of Medical Schools Involved</u>	<u>Total Volume Of Grant Support (Millions)</u>
1972	6	\$6.6
1973	7	5.8
1974	8	7.4
1975	4	2.1
1976	3	1.8
1977	1	1.5
1978	1	2.8
1979	1	2.1
1980	1	3.2

The nine medical schools receiving Financial Distress Grants during the eight-year period from 1972-1980 were:

- Creighton University School of Medicine
- George Washington University School of Medicine
- Georgetown University School of Medicine
- Meharry Medical College
- New York Medical College
- St. Louis University School of Medicine
- Temple University School of Medicine
- Tulane University School of Medicine
- University of Nevada-Reno, School of Medical Sciences.

LEGISLATIVE BACKGROUND OF FINANCIAL DISTRESS

The Financial Distress Grant Program was one component of a broad federal commitment to offer a stable source of support to health professions schools to enable them to meet the nation's health manpower needs. Growing concern regarding a shortage of health manpower led the Federal Government to make an explicit commitment in 1963 to increase the supply of health personnel. Since that time, a series of bills have been enacted to assist medical schools. The principal provisions and congressional intent of those bills, as they relate to the development of the Financial Distress Grant Program, are described in the paragraphs that follow.

Health Professions Educational Act of 1963. This legislation provided matching grants for construction, expansion, remodeling, and repair to schools of medicine and other schools of health sciences. It also furnished loans to students in medicine, osteopathy, and dentistry.

Health Professions Educational Assistance Amendments of 1965. This bill extended the program of matching grants introduced in the 1963 legislation, and introduced two new types of grants designed to expand enrollments and help financial solvency where schools had shortages in operating funds:

- Basic Improvement Grants (BIG) awarded grants to eligible schools for curriculum improvements.

- Special Improvement Grants (SIG), the predecessor of Financial Distress Grants, awarded grants to schools in need of assistance in maintaining accreditation or a specialized school activity.

Health Manpower Act of 1968. With the conviction that the nation's need for health manpower remained urgent and that many health professions schools were experiencing serious financial difficulty, the Federal Government sustained and expanded its commitment to supporting health professions education. The 1968 act extended the construction grant program, renamed the BIG grants "Institutional Grants," amended the formula to encourage further expansion of enrollments, renamed the SIG grants "Special Projects Grants," and specified that priority for these grants should be given to schools in financial difficulty.

Health Training Improvement Act of 1970. This act offered emergency assistance for medical and dental schools in extreme financial distress. In addition, the legislation directed the Secretary of the former Department of Health, Education, and Welfare to determine the need of medical and dental schools for this assistance and to report the findings to Congress.

Comprehensive Health Manpower Training Act of 1971. This act instituted the Financial Distress Grant Program, as part of an increased federal commitment to health professions education. Under this legislation, several types of grants were authorized, as follows:

- Capitation Grants, which provided a major and expanded source of formula grants for institutional support
- Financial Distress Grants, which, under separate authority, offered financial assistance to schools experiencing acute financial difficulties despite capitation grant awards
- Construction Grants, which provided funds for the construction of teaching facilities for medical, dental and other health professions schools
- Start-Up Grants, which provided start-up assistance for new schools of medicine, dentistry, and osteopathy
- Special Project Grants, which provided assistance in meeting the cost of special projects involving training programs and other designated areas
- Conversion Grants, which allowed medical schools to change from two-year to four-year programs.

The Comprehensive Health Manpower Training Act of 1971 revised and extended the Construction Grants from the 1963 act and the Special Projects Grants from the 1968 act.

Health Professions Educational Assistance Act of 1976. The Financial Distress Grant Program of 1971, originally authorized through 1974, was extended under this act through 1980, again as part of a large-scale revision and extension of health manpower programs. Between 1974 and 1976, the emphasis in congressional debates shifted from a concern with increasing the aggregate supply of health professionals, to a desire to improve the distribution, geographically and by speciality, of the nation's health manpower. This act, therefore, revised and extended the Capitation, Construction, Start-Up, and Special Projects Grants, in addition to Financial Distress Grants. The authority of this act expires at the end of fiscal 1980. Health manpower issues are, therefore, once again a focus of congressional debate.

III - ASSESSMENT OF SUCCESS OF THE
INDIVIDUAL SCHOOLS

III - ASSESSMENT OF SUCCESS OF THE INDIVIDUAL SCHOOLS

This chapter presents case studies on each of eight medical schools that were recipients of Financial Distress Grants. It first presents an overview of the analysis performed on each school. It then presents for each school a discussion of its background, its objectives in seeking the grant(s), the actions that were taken by the school, and a summary of its success in achieving the objectives.

OVERVIEW

General Structure

Each Financial Distress Grant was awarded for one year, during which the school would be expected to initiate actions designed to improve its financial position. The funding was also intended to help prevent a school from taking austere measures that could otherwise prove damaging in the longer term. Seven of the medical schools that received a grant proposed a series of actions that would improve their fiscal posture. One school received funds solely to implement actions that would allow it to maintain its accreditation.

For each year in which a Financial Distress Grant was requested, each school submitted a detailed, formal application that proposed actions and developed a plan. During site visits, these actions were discussed with representatives of each school. Particular attention was given to actions that were actually taken, as well as to their effect on a school's financial position. On the basis of these interviews and the analysis of pertinent data, each action was assessed in terms of the extent to which it influenced the financial position of the medical school.

To ensure anonymity, the institutions are coded with the letters A through H. For the further safeguarding of anonymity, certain identifiable data (such as tuition information) have been rounded or expressed as percentages.

Evaluation Criteria

Evaluation criteria were defined to categorize the "success" of the individual actions that were taken to improve the position of a school. Those actions that had a measurable impact on a school's operating budget were classified, as follows:

- Major impact - actions that subsequently provided at least 10 per cent of the school's operating budget
- Moderate impact - actions that subsequently provided 5 per cent to 10 per cent of the school's operating budget
- Minor (or no) impact - actions that subsequently provided less than 5 per cent of the school's operating budget.

Actions whose effects were nonfinancial, or less precisely measurable, were classified subjectively into the three foregoing categories based on their impact on the following criteria:

- Establishment of a base for the school's continuing financial stability
- Strengthening of the management and control of school operations
- Avoidance of an adverse impact on program quality
- Maintenance of full accreditation or alleviation of a situation expected to affect future accreditation.

Caution Regarding Comparisons

Each medical school proposed a unique plan to improve upon its financial or accreditation situation. These plans were the product of the school's inherent strengths and weaknesses, its original financial position, its unique relationships within and outside of its university, and the extent to which a series of options were available. For this reason, each school is discussed and assessed individually. Further, because each school had its own special circumstances, caution is suggested in making absolute comparisons among schools.

SCHOOL A

This section presents background information concerning the involvement of School A in the Financial Distress Grant Program. It also discusses the medical school's objectives in seeking the Financial Distress Grants and the actions taken to alleviate financial distress, and summarizes the school's success in achieving its objectives.

BACKGROUND

School A is a private four-year medical college that is neither state affiliated nor part of a larger university. The school has a class size of 180 for the first two years and 200 for the third and fourth years. It is located adjacent to a county hospital that serves as one of the medical school's primary teaching facilities. The school also has a number of affiliation agreements or teaching contracts with other public and private hospitals.

At the time the medical school sought financial distress funding, it was incorporated with an urban hospital as a single entity. This corporation had incurred annual operating deficits of between \$1 million and \$2 million annually for a number of years, before applying for its first Financial Distress Grant. Between fiscal 1969 and 1971, almost \$2.5 million of these deficits were offset by Special Projects Grants awarded by the former U.S. Department of Health, Education, and Welfare. The remainder of the operating deficit was defrayed by endowment funds.

Most of the corporation's endowment funds were liquidated in 1969 to repay bank loans, to finance accumulated deficits, and to fund current operations. The corporation exhausted its endowment funds in 1970, thereby causing critical cash-flow difficulties that persisted throughout fiscal 1970 and 1971. Therefore, the school applied for aid under the Financial Distress Grant Program for fiscal 1973, viewing the program as the successor to previous federal programs (particularly the Special Projects Grants) which had supplied major sources of funding. The school sought two consecutive Financial Distress Grants to meet its operating deficit, and to avoid taking actions that could have had an adverse impact on program quality.

When the school first applied for a Financial Distress Grant, it cited a number of specific problems:

- The medical school was, at that time, a joint corporation with an urban hospital. The hospital had, for years, been a financial drain on the medical school and, although it was operating near the break-even point in 1972, the forecast for 1973 and subsequent years was unfavorable.
- The school was in the process of moving to a suburban community. Although the relocation was projected to be beneficial financially and programatically over the long run, it drained school resources in the short term.
- The school lacked a financial base. As stated, all of the assets in endowment funds had been sold by the end of 1970.
- The school had no clinical practice plan to produce revenue or to offset operating expenses.
- The school had difficulty attracting contributions, perceived to be due to a lack of public awareness or a civic or religious constituency.
- The school lacked strong budgetary control systems.

OBJECTIVE OF THE GRANTS

The objective of the Financial Distress Grants was to provide the medical school with funding to meet its operating deficit, while it took a series of steps to alleviate its financial difficulties over the longer term. In fiscal 1973 and 1974, the medical school applied for and received two grants that totalled approximately \$1 million.

The school focused its efforts on relocating from its urban headquarters to the planned suburban site; building a suitable teaching facility at the new location; disbanding, if possible, the corporation joining it to the urban hospital; improving its fund-raising efforts; and obtaining additional sources of income.

ACTIONS TAKEN BY THE SCHOOL

The school undertook a number of actions designed to improve its financial position. These actions varied in the importance of their impact on the school.

- Major impact: relocation of the medical school, obtaining a permanent source of external funding, increase in tuition, and curriculum changes to increase capitation funding
- Moderate impact: salary controls, control of faculty and staff positions, and internal cost studies
- Minor or no impact: efforts to increase contributions and attempts to establish a clinical practice plan.

The various actions, each of which is defined and detailed in the sections that follow, have been categorized in terms of their "success" in alleviating the school's financial distress.

Major Impact

The actions that had a major impact on the schools' financial position are discussed in the paragraphs that follow.

Relocation of the medical school. The most significant factor in the overall financial picture of the medical school was its move, in the early 1970s, from a low-income metropolitan area to an upper-middle income suburban location. Initially, this relocation was sought to achieve four principal objectives, as follows:

- To establish a separate identity for the medical school, independent of the urban hospital with which it was incorporated
- To improve the quality of research and patient-care facilities available to the school
- To become a regional medical school with a distinct identity, rather than to continue as one of seven urban medical schools
- To establish a franchise or constituency for the medical school in the suburban community, or in the region, that would supply additional funding for the medical school through contributions and grants.

In the late 1960s, the school had considered a number of proposals from hospitals, county governments, and others in the field of health care interested in acquiring or supporting a medical school. Of these proposals, the school decided to accept an offer that allowed the school to remain independent and to relocate to a suburban county (about an hour away from the school's urban site).

Initially, the school had also planned to finance, build, and manage a new hospital that would replace the existing county hospital facility. In 1972, however, the school was advised that federal funding for the construction of the new hospital would be in the form of a loan, rather than a grant. This change, which occurred during the construction planning phase, created a situation that was beyond the financial capabilities of the medical school or the corporation. The county government intervened, assuming the title to the new hospital and financing it through county funding sources.

The overall effect of relocating to the new suburban location had a major, though not quantifiable, impact on the school:

- The school established an attractive, modern location for the long term.
- The school now serves a county and region that have no other medical schools.
- The school established an independent identity from that of the urban hospital (which remained an affiliate and also part of the same corporation until 1979, as will be discussed later in this analysis).
- The school benefited from improved patient-care facilities at the newly constructed county hospital. Certain of the medical schools' educational programs are based at this hospital, which functions as a tertiary-care (referral) hospital for the region.

Obtaining a permanent source of external funding. Although not contemplated by the school in its applications for Financial Distress Grants, the school secured a permanent source of external funding in the mid-1970s. This source, a religious organization in the state, refinanced the outstanding loans of the medical school/urban hospital corporation, thereby reducing the amount of the loan and the monthly loan payments. In exchange, the medical school agreed to a reorganization of the board of directors, including the appointment of a number of lay directors selected by the religious organization.

At the same time that the religious organization assumed financial responsibility for the medical school, it established tighter budgetary policies and control systems for the school. Despite the connection with the religious organization, the medical school continues to operate as a private, nonsectarian institution.

Increase in tuition. The school significantly increased its tuition, and the resulting increase in income proved to be a major factor in improving its financial position. In fiscal 1972, (the year before the first Financial Distress Grant was received) tuition was approximately \$2,000 and provided almost \$1.9 million of income to the school. Tuition was increased by approximately 12 per cent annually from fiscal 1973 through fiscal 1976. Then, between fiscal 1976 and fiscal 1977, tuition rose 45 per cent. In fiscal 1978 and 1979, tuition was increased 6 per cent and 11 per cent, respectively. The following table presents these tuition increases, expressed as a percentage of 1972 tuition:

<u>Fiscal Year</u>	<u>Tuition</u>
1972	100%
1973	157
1974	177
1975	199
1976	223
1977	323
1978	343
1979	380

Between 1972 and 1979, approximate average class size increased from 140 to 190, and total tuition income grew to \$5.8 million, more than triple the amount of seven years earlier. As shown in the following table, tuition income increased over this period from approximately 3 per cent to nearly 8 per cent of the school's total operating budget:

<u>Fiscal Year</u>	<u>Tuition Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1972	\$1.9	3%
1975	3.5	5
1979	5.8	8

Tuition increases have helped the school financially and, in the assessment of school administrators, will be viable and essential sources of funding.

Efforts to increase capitation funding through curriculum and enrollment changes. The school made significant modifications in its curriculum and enrollment to increase the amount of federal and state capitation it received. To increase its federal capitation awards, the school shifted in 1972 from a four-year to a three-year program. The school was able to graduate two classes in 1975, thus obtaining additional capitation funds for its "bonus class." The school has subsequently returned to a four-year program, graduating the last of the three-year students in 1978.

The school also took advantage of three distinct state-aid programs. The first program, which expired in 1974, was an expansion program that paid \$6,000 for each additional student over the average number enrolled in a certain base period, up to a maximum of 25 additional students. The second program furnished capitation aid based on the number of degrees granted. The third program provided funds based on total student enrollment above those positions funded under the expansion programs.

To take full advantage of these programs, the school increased its total enrollment from approximately 520 in 1971, to about 600 in fiscal 1973 and 1974. In fiscal 1975, the school increased its total enrollment to more than 800, graduating a "bonus class" and increasing the number of third- and fourth-year students, specifically to receive additional funds under the state's program for medical school graduates.

The school estimates that through restructuring class sizes, converting to a three-year program, and then returning to a four-year program, it was able to recognize an additional \$4.5 million in federal and state support. According to school officials, these changes were made without significant increases in the number of faculty or staff.

Moderate Impact

The actions that had a moderate impact on the financial position of the school are discussed in the paragraphs that follow.

Salary controls. Since the early 1970s, the school has maintained faculty salary increases below the annual increase in the consumer price index. Salary increases for faculty and managerial or administrative staff averaged between 5 per cent and 6 per cent annually during the 1970s. Technical and secretarial employees, and most of the hospital staff, were outside of these salary control policies because they were union members.

Despite the fact that the salaries of many of the staff were not subject to the same salary controls, total salary expenses increased by 33 per cent between 1972 and 1979, but remained level as a percentage of the total operating expenses throughout this period (approximately one-third of the total operating budget).

Control of faculty and staff positions. The school held the number of faculty and staff positions essentially level throughout the early 1970s. From fiscal 1973 through fiscal 1976, the total number of paid, full-time faculty (including those under affiliation contracts) fluctuated between approximately 340 and 365 members. It should be noted that, in the early 1970s, while the school increased its enrollment to generate additional state and federal funding, the number of faculty remained generally level. Since fiscal 1977, the number of full-time faculty has been increased only as the positions have been supported by affiliation contracts.

Internal cost studies. The school conducted internal cost studies prior to receiving the Financial Distress Grants, and again in the mid-1970s. The earlier studies made the school's administrators aware of the sources and uses of the school's funds and improved their understanding of the costs associated with the various programs and services provided by the medical school.

In 1976, when the new board of directors was appointed, it launched a cost-control program that involved a number of cost-evaluation studies. These studies have enabled the medical school to control planned expenditures more tightly and have created an atmosphere of cost-consciousness at the medical school.

Minor Or No Impact

The actions that had a minor (or no) impact on the financial position of the medical school are discussed in the following paragraphs.

Efforts to increase contributions. Although the school expected to increase its level of gifts and contributions substantially as a result of its relocation to the suburban site, this expectation was never realized. A committee of community leaders was established soon after the relocation to solicit contributions. It had difficulty, however, implementing its programs and ultimately was disbanded. The level of gifts and contributions has fluctuated rather dramatically over the past eight years. These sources have, however, never provided

as much as 2 per cent of the school's total operating budget. As shown in the following table, gift income for current operations has typically been less than 1 per cent of the total operating budget:

<u>Fiscal Year</u>	<u>Gifts And Contributions (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1972	\$0.7	1½
1973	0.6	1
1975	0.5	1
1976	1.2	2
1978	0.3	0

The dramatic increase in contributions in fiscal 1976 was the result of a special fund-raising campaign to save the urban hospital that was incorporated with the medical school. Although the level of total contributions increased markedly, the operating budget was not substantially assisted.

Efforts to establish and gain income from a clinical practice plan. Although the school cited a desire to establish a clinical practice plan that would produce income for the medical school, that desire was not realized until 1980. Throughout the 1970s, the school had little control over the outside income of its faculty members. The school had an official policy that faculty members were allowed to spend no more than one day each week caring for their private patients. However, no system to enforce this policy existed. Faculty members were permitted to retain all earnings from their private practice, paying an amount that covered the direct overhead cost of a suite of offices.

Throughout the 1970s, the practice plan issue was debated by the faculty and by school administrators. In 1980, departmental practice plans and a central billing system were initiated. Patient care activities will now be governed by departmental plans, which are not expected to be uniform. Some proportion of the total income from the plans will be returned to the medical school, although the specific percentage has not yet been determined.

SUMMARY

The two years of financial distress funding provided the school with short-term financial support, while it took steps to address its underlying financial problems.

- The school relocated to the suburban location, thereby improving its hospital and basic science facilities. This move has proven financially and programmatically beneficial over the long run.
- As a short-term strategy, the school increased state and federal funding by adjusting its curriculum and enrollment to meet funding guidelines.
- In addition, the school was able to obtain an external source of permanent funding, not specifically contemplated in its grant application. As a result, the school's budgeting policies and processes were tightened and additional financial controls were implemented.
- The school was able to divest itself of the urban hospital and now operates as a separate corporation.

These actions, among others, have enabled the school to attain financial stability.

SCHOOL B

This section reviews the involvement of School B in the Financial Distress Grant Program. It presents background information concerning the school, its objectives in seeking Financial Distress Grants, the actions taken to alleviate financial distress, and a summary of the school's success in achieving its objectives.

BACKGROUND

School B is a four-year medical school that is part of a state-related university. The school, which has a class size of approximately 180, is part of a medical center that also includes a university-owned hospital.

Prior to applying for financial distress funding, the school had incurred annual operating deficits that were subsidized by the parent university. These deficits totalled \$3.4 million in 1972 and 1973 (or 6.5 per cent of total operating expenditures during that period). In 1974, however, the university hospital, reacting to its own budgetary problems, reduced the level of reimbursement to the medical school by approximately \$1.2 million. This reduction created a major revenue shortfall for the medical school, in addition to the school's recurring operating deficit. Therefore, the school initiated several actions, as follows:

- The school reduced its expenditures by approximately \$600,000 through the termination of various positions.
- Departmental practice plans absorbed \$600,000 of the costs, even though this placed many of these plans in a deficit position.
- The school applied for a Financial Distress Grant to meet its operating deficit.

During the application process, however, the school became aware of the impact of the university's new approach to allocating its overhead expenditures. Charges to the school for overhead costs increased the estimated annual deficit for the medical school to approximately \$2.3 million.

The first application for financial distress funding cited the problems stated previously, as well as the view that the medical school was having difficulty recruiting four departmental chairpersons and attracting qualified faculty members.

The school also submitted an application for a Financial Distress Grant during the following year. At that time, the school was able to convince the university that the cost-allocation formula had an unusually adverse impact on the medical school. Specifically, the medical school did not share in the revenues from increased state appropriations, but did share in the costs that were allocated based on these additional appropriations. The university, therefore, agreed to fund a 5 per cent school deficit. The medical school, however, needed to fund the deficit in excess of 5 per cent, to recruit and fill some vacant chairs, and to improve its management information capabilities for internal control.

OBJECTIVE OF THE GRANTS

The objective of the Financial Distress Grants was to provide the medical school with funding to meet its current operating deficit, while it took a series of steps to alleviate its financial difficulties over the longer term. In fiscal 1974 and fiscal 1975, the school applied for grants totalling \$5.8 million to fund its entire operating deficit. The school, however, received grants that totalled only approximately \$845,000, or 1.5 per cent of operating expenditures over that period.

The school focused its efforts on the need to expand the practice plan into a major source of income, to obtain equitable funding for services provided to the university hospital, and to obtain other sources of income.

ACTIONS TAKEN BY THE SCHOOL

The school undertook a number of actions designed to improve its financial position. The impact of these actions varied:

- Major impact: increase in clinical practice plan income, changes in funding relationships with the university hospital, and increase in tuition and fees
- Moderate impact: control of faculty salaries and changes in management structure and personnel
- Minor or no impact: internal cost studies, actions to augment capitation, efforts to increase contributions, and cost control in sponsored research programs.

Major Impact

The actions that had a major impact on the school's financial position are discussed in the paragraphs that follow.

Increase in clinical practice plan income. A major contributor to the operating budget of the school is the clinical practice plan. The new plan, which was developed in 1974 and approved by the board of trustees in 1977, replaced a set of 17 essentially different departmental practice plans that had been in effect since the mid-1960s. Most of these plans had made uniform allocations to plan participants, without any provision for incentive or bonus pay. The plans returned up to 25 per cent of the net balance to the medical school; the remaining 75 per cent of the balance was credited to the departments. Because there was neither a central control of billing nor budgeting of the individual plan accounts, the departments had substantial individual flexibility.

The new practice plan formalized policies and centralized billings with a system that covered all patient care income, and included the potential of incentive pay of up to 25 per cent of base salary for clinical faculty members. The limit of 25 per cent for incentives was put into effect to allow greater discretion by the department heads and the dean for funding academic programs.

Development and structuring of the clinical practice plan provided a substantial source of funding for the school. As shown in the following table, after direct expenses, the practice plan generated approximately \$10 million in revenues during 1979:

<u>Fiscal Year</u>	<u>Net Revenues (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1974	\$ 4.9	18%
1976	9.0	29
1979	10.2	22

Changes in funding relationship with the university hospital. The school's financial distress situation was triggered in 1974 by a reduction in the level of reimbursement by the university-owned hospital. The funding of approximately \$3.0 million in 1973 was reduced to \$2.0 million in 1974 and to \$1.7 million in 1975. This reduction was prompted by the hospital's financial problems, brought on by its location in a low-income area where patients lacked alternative health care sources.

In 1975, the university and the medical school administrators discussed the hospital's problem with various state government representatives. The hospital had an accumulated debt of approximately \$25 million at that time, and the prospects of improving its financial situation were limited. As a result of these discussions, and with the view that the hospital was a public, state, and community responsibility, rather than a problem of the university, the hospital was allocated \$2.5 million from the state.

Moreover, the governor established a "blue-ribbon" committee to study the hospital and its relationship to the university and to the medical school. The committee subsequently reported that the hospital was in financial difficulty because of the high incidence of nonpaying patients, many of whom were on welfare, and that some of the responsibility of maintaining the hospital rested with the state. As a result, the state cancelled its program to build a new clinical teaching building and hospital, and the remaining funds (approximately \$25 million) were used to cover the hospital's accumulated debt. The state then agreed to offer a continuing subsidy to the hospital of approximately \$2.5 million annually, contingent upon passage of appropriate legislation each year.

The hospital and school administrators then reassessed the "level of effort" of the medical school for the provision of services to the hospital. As a result of this reassessment and the hospital's improved financial condition, the school was able to obtain an increasing and equitable reimbursement. The extent of the reimbursement has been on a "per cent of effort" formula negotiated at the time of budget preparation. The impact on the school has been significant, as shown in the table below:

<u>Fiscal Year</u>	<u>Total (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1974	\$2.0	7%
1977	3.2	10
1979	4.2	9

Increase in tuition and fees. The school increased significantly its tuition, and the resulting increase in tuition income proved to be an important factor in improving its financial position. In fiscal 1974, tuition was \$1,300 for state residents and \$2,600 for nonresidents; tuition then provided approximately \$1 million in income to the school. In-state tuition increased annually by at least 30 per cent in five of the next six years. By 1979, in-state tuition had increased by 415 per cent over the 1973 level. Out-of-state tuition

tuition also increased substantially, with an increase of 237 per cent. In so doing, however, the differential between in-state and out-of-state tuitions decreased from 1974 through 1979 period from 100 per cent to 40 per cent.

The following table shows the tuition increases expressed as percentages of 1971 tuition for resident and nonresident students:

<u>Fiscal Year</u>	<u>Resident</u>	<u>Nonresident</u>
1971	100%	100%
1972	100	100
1973	100	100
1974	134	125
1975	155	144
1976	206	192
1977	309	240
1978	412	288
1979	515	337

With no appreciable change in class size from 1974 through 1979, total tuition income increased to \$3.7 million, or more than triple the amount of the previous five years. Most of this increase in tuition revenue resulted from the increases in in-state tuition, because state residents have represented approximately 85 per cent of the school's enrollment throughout this period.

As shown in the following table, the tuition income increased over this period from 4 per cent to 8 per cent of the school's total operating budget:

<u>Fiscal Year</u>	<u>Tuition Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1974	\$1.1	4%
1976	2.7	5
1979	3.7	8

Moderate Impact

The following actions had a moderate impact on the school's financial position.

Control of school contribution to faculty salaries. The school took several actions to control its contribution to faculty salaries:

- The school established a policy that enabled clinical faculty members to "earn" additional salary increases through the practice plan. This policy provided an incentive for the faculty members to generate billings for the plan.
- Base salaries for clinical faculty were held to approximately the 80th percentile of salaries in the Association of American Medical Colleges' annual salary survey.
- Increases in base salaries for all faculty were below the increase in the cost-of-living, averaging 6 per cent annually since 1974.
- Salary increases for the medical school were held within the universitywide guidelines.

By imposing salary controls, the school has been able to avoid an undetermined amount of increased costs.

Changes in management structure and personnel. During fiscal 1975, the school appointed a new financial officer and hired support personnel to perform financial and budgeting analyses. These changes broadened the base of experience in the school's management and helped to improve the school's budgeting process and financial reporting systems.

Minor Or No Impact

The following activities had a minor or no impact on the school's financial position.

Internal cost studies. In fiscal 1975, the school commissioned a comprehensive cost-allocation study, as recommended under the financial distress process. According to school administrators, the study confirmed their assessment of the financial situation at the school, without revealing new sources of revenues or cost-control opportunities. Overall, internal cost studies have had little direct impact on improving the financial situation of the medical school, although they were useful tools for school administrators.

Efforts to increase state capitation. Throughout the 1970s, the school appealed to its state legislature for an increase in the level of state capitation funding. The efforts to obtain increased funding included working through

the association of medical school deans in the state. These efforts were unsuccessful, however, in raising the level of capitation support, which had remained at approximately \$5.3 million annually (or approximately 12 per cent of the school's operating budget) since fiscal 1974.

Efforts to increase contributions. In 1974, the school identified the need for an improved fund-raising program to help meet the medical school's operational expenses. Efforts were focused on raising money for the construction of the hospital, rather than on generating contributions for general operational support. Since 1971, therefore, the level of contributions has remained stable, at less than \$200,000 annually.

SUMMARY

The two Financial Distress Grants offered the medical school short-term financial support. The actions proposed and taken by the medical school generally were successful in improving the financial position of the school. While the total operating expenditures of the school increased by nearly 170 per cent between 1972 and 1979, the deficit (in accordance with the university's cost allocation method) decreased from approximately 6 per cent of the operating expenditures to 2 per cent, although it is still nearly \$1 million. The most significant sources of income for the medical school include: the practice plan, contributing more than 20 per cent of the operating budget; state capitation appropriations, contributing approximately 12 per cent of the operating budget; reimbursements from the university hospital, amounting to more than 9 per cent of the budget; and tuition which accounts for 8 per cent of the medical school's budget.

SCHOOL C

This section discusses the involvement of School C in the Financial Distress Grant program. The background of the school, its involvement in seeking the Financial Distress Grants, the actions it has taken to deal with financial distress, and a summary of its success in achieving its objectives are also presented.

BACKGROUND

School C is a four-year medical school that is part of a private university. The school has a class size of approximately 205 and is part of a medical center that also includes a wholly owned hospital and ambulatory clinic. As is typical of medical schools, it has affiliations with a number of other hospitals and medical facilities.

The school has incurred a series of operating deficits, including a total of \$4.5 million (or almost 13 per cent of total operating expenditures) from fiscal 1969 through fiscal 1971. The deficits incurred in the late 1960s were accumulated in a current (unrestricted) fund of the university, and finally liquidated in 1980 by depleting the emergency reserve fund of the university. By that time, the total of the reserve fund was sufficient to cover the university's accumulated deficit in the current fund (including the deficit of the School of Medicine).

School C (as well as School D) had applied for state-like financial assistance for fiscal 1971 from the District of Columbia and the federal government. The assistance was authorized, but funds were not appropriated in that year or in any of the succeeding years until fiscal 1975. School C applied for a Financial Distress Grant for fiscal 1972, citing a number of significant problems:

- State or "state-type" assistance had not and was not available to the school.
- Nonacademic salaries had increased significantly as a result of changes in the minimum wage laws, competition from recently unionized employees at other hospitals, and other local market salary conditions.

- Facilities had been expanded in response to the federal initiative to assist in resolving the nationally-declared shortage of physicians in the country. In participation, the school had, in turn, incurred significant increases in maintenance, housekeeping, and utility expenses related to the expansion of space.

OBJECTIVES OF THE GRANTS

The objectives of the Financial Distress Grants were to provide the medical school with funding to meet its annual operating deficits while it took a series of steps to strengthen its financial position. Beginning in fiscal 1972, the school applied for three grants and received a total of almost \$5 million.

The school focused its efforts on generating additional income through the areas of permanent state-like funding, tuition increases, clinical practice revenues, and strengthened management and cost controls.

ACTIONS TAKEN BY THE SCHOOL

The school undertook a number of actions to improve its financial position. These actions varied in the importance of their impact on the school:

- Major impact: increases in tuition, efforts to increase income from the clinical practice plans
- Moderate impact: internal cost studies, improvements in management structure and efforts to obtain permanent state-like support
- Minor or no impact: faculty position control, changes in facilities management, and efforts to increase contributions.

Each of these actions is discussed in the paragraphs that follow.

Major Impact

The actions that had a major impact on the school's financial position are discussed below.

Increases in tuition. Since the early 1970s, tuition at the school has significantly increased and has proven to be a major contributor to the school's total operating budget. The school now has one of the highest tuitions of any

medical school in the country. In fiscal 1971 (the year before the first Financial Distress Grant was received), tuition was \$2,600. Increases in tuition schedules were designed and implemented on a staggered basis to avoid penalizing students who had enrolled at lower tuition levels. The following table shows the tuition levels, by class, expressed as a percentage of 1971 tuition:

<u>Fiscal Year</u>	<u>First Year</u>	<u>Second Year</u>	<u>Third Year</u>	<u>Fourth Year</u>	<u>Average Tuition For Four Classes</u>
1971	100	100	100	100	100
1972	108	100	100	100	102
1973	108	100	100	100	102
1974	115	115	115	115	115
1975	135	135	135	135	135
1976	192	173	173	173	178
1977	262	208	208	208	222
1978	481	404	337	317	385
1979	481	481	462	385	452

Tuition for first year students increased almost five times from 1971 to 1979. The largest increase in tuition was instituted in 1978, the year that the school ceased receiving either state-like funding or financial distress funding.

Tuition income increased by \$8.2 million between 1971 and 1979, to more than six times the amount in 1971. Much of the increase in tuition income resulted from concurrent increases in enrollment, from 120 in 1971 to 205 by 1975. As shown in the following table, tuition income grew from 12 per cent of the school's total operating budget to 29 per cent in fiscal 1979:

<u>Fiscal Year</u>	<u>Tuition Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1971	\$1.6	n/a
1972	1.7	n/a
1973	2.1	n/a
1974	2.3	12
1975	2.9	13
1976	3.8	15
1977	4.7	17
1978	8.2	27
1979	9.8	29

While these tuition increases have helped the school financially, school administrators felt that the effect on the number and quality of applicants has not been negative. Assessments of actual enrollments indicates that the tuition increases have not caused a shift in the socio-economic mix of the school students, and that MCAT scores and GPA averages have continued to advance.

Efforts to increase income from the clinical practice plans. The departmental clinical practice plans are major contributors to the operating budget of the school. These plans have evolved gradually since the late-1960s from informal arrangements with the faculty members to well-articulated, written plans that are administered by each of the seven departments that provide patient care. Although there are variations among the departmental plans, they all follow three common guidelines:

- All plans prohibit any outside practice and require that all patient care income be credited to the department.
- Administrators at the medical center may audit any plan at any time and, at a minimum, perform an annual audit of each plan.
- Each plan requires that all full-time faculty members participate in the plan.

In addition to departmental support, each plan contributes to the general support of the school.

The formalization of the practice plans has provided a substantial funding source for the medical school. The practice plans, on average, pay approximately 50 per cent of the total clinical faculty salaries. In addition, the plans support other expenses including occupancy costs, insurance, staff salaries and general departmental expenses that were previously paid by the medical school. The practice plans generated approximately \$6 million in gross billings in 1979 and provided approximately \$2.3 million in income to the medical school in 1979, up from approximately \$26,000 in 1975.

Moderate Impact

The actions that had moderating impact on the financial position of the school are discussed in the following paragraphs.

Internal cost studies. The school has conducted a number of internal cost studies since 1970 and continues to do so. A medical center fiscal management program was developed in 1970 and continuously improved. In 1978, fiscal/administrative processing was refined and expanded in each medical center school. These studies have proven significant because they have enabled medical center and school administration to intensify and expand methodology for identifying specific internal costs. These efforts, in turn, resulted in the development of more intense budgeting processes for the school. In addition, from internal cost studies, a sophisticated university, medical center, and school cost allocation system was developed. This system allocates to campus, center, school, department, or other function that benefits from the service, rather than paying these charges from a single medical school account.

According to school administrators, many of the budgeting reforms that were implemented in 1970 and expanded throughout the 1970s stemmed from the stimulation of original internal cost studies. The school revises the cost data annually, in conjunction with the annual budgeting process. On an ongoing basis, cost studies are used as a management tool and for the Management Information System to guide the allocation of resources and costs.

Improvements in management structure. In 1970 the office of the vice president for medical affairs was strengthened to better control and coordinate the programs, budget, and resources of the medical school. Two additional steps were taken to improve management processes.

- First, medical center administrators adopted the policy that each of the units within the medical center would be a self-supporting entity and would operate on a balanced budget.
- Second, programs were initiated to create staff positions in the dean's office, to establish fiscal objectives, ensure compliance with these objectives, and prepare periodic budget plans.

The school also extended its budgeting process beyond a one-year time horizon to the preparation of two-year and five-year projections.

Overall, these changes in management structure and processes enabled the school to stabilize fiscal operations and to create a commitment of cost consciousness among faculty and staff members.

Efforts to obtain permanent state-like funding. Throughout the early 1970s, the school sought federal or state-like government support. Although state-like funds were authorized under a 1970 act, the money was not appropriated until later acts. Yearly, from 1972 through 1974, the school applied for and was awarded a grant under the Financial Distress Grant Program.

In 1974, the 1970 legislation was extended and matched with a separate federal appropriation. From fiscal 1975 through fiscal 1978, the school received a capitation award of \$5,000 per student, up to a maximum of 820 students. Funds received from the government, through this state-like funding program, proved beneficial to students, and useful to the school; these funds represented a substantial although declining proportion of the school's total operating budget between 1975 and 1977, as shown in the following table:

<u>Fiscal Year</u>	<u>State-Like Funding</u>	<u>Per Cent Of Operating Budget</u>
1975	\$4.1	19%
1976	4.1	16
1977	4.1	12
1978	0.0	0

Minor (Or No) Impact

The actions that had a minor (or no) impact on the school's financial position are discussed below.

Faculty position control. In the early 1970's the school established a policy that prohibited the addition of faculty unless a long-term external funding source could be found to support each additional position. The policy of strictly controlling the number of faculty has created pressures within the medical school. This policy eventually was modified as grant and contract resources increased, and faculty practices plans became more productive.

Changes in facilities management. In 1970, the medical center established an office of facilities and material to oversee three functions for all schools:

- Centralization of inventory onto a computerized control system
- Management and maintenance of equipment
- Supervision of facilities utilization and maintenance.

Under the direction of this office, an equipment inventory system was designed and implemented. This system is used in the purchasing and budgeting processes. Outside contractors were hired to maintain the buildings. Because the school's facilities were either newly constructed or renovated in the early 1970s, the maintenance costs, and cost-savings possible, have been minor.

As energy costs have risen, by contrast, the school has recognized substantial cost savings through tightening its controls on energy utilization. School administrators predict that these energy conservation measures will become progressively more critical to the school's future financial position, given the anticipated continued increases in these costs.

Efforts to increase contributions. The school has been able to increase its alumni contributions and gifts for current operations. A number of steps led to this improved ability to attract contributions:

- In the early 1970s, fund raising was first identified as a separate operation within the medical center.
- The fund raising staff was enlarged from one person to a current total of five who cultivate foundations and individual donors.

Gift income for current operations increased significantly over the 1971-1979 period, with the rate of increases accelerating in recent years. However, these efforts were primarily related to independent programs developed during the late 1960s and expanded during the 1970s, rather than to the Financial Distress Program.

SUMMARY

The three grants funded through the Financial Distress Grants Program (1972-1974) provided the school with short-term financial support which assisted in offsetting operating deficits. The school received funding under the D.C. Manpower Bill for three consecutive years (1975-1977). In 1978, the school instituted significant tuition increases. During the early 1970s, the school reorganized and installed sound financial policies and procedures that are still in effect. In addition, the departmental practice plans that were formalized in the early 1970s have become significant sources of income for the departments, covering costs that have escalated significantly in recent years.

SCHOOL D

This section discusses the involvement of School D in the Financial Distress Grant Program. It includes discussions on the background of the school, its objectives in seeking the Financial Distress Grants, the actions it has taken to alleviate financial distress, and a summary of its success in achieving its objectives.

BACKGROUND

School D is a four-year medical school that is part of a private university. The school has a class size of approximately 150, and is part of a medical center that also includes a wholly owned hospital and faculty group practice. As is typical of medical schools, it has affiliations with a number of other hospitals and medical facilities.

Before applying for financial distress funding, the school had incurred annual operating deficits since fiscal 1960. These deficits grew from approximately \$150,000 in 1969 to nearly \$2 million in fiscal 1971. From 1960 through 1967, the relatively small deficits of the medical school (averaging approximately \$390,000 annually) were covered by a medical science fund that was comprised of the excess revenues of the departments of anesthesiology, pathology, and radiology. The medical science fund was depleted by 1970 and the school was forced to liquidate a portion of its endowment funds. Then, in 1971, the school received a Special Project Grant to cover its deficit. In fiscal 1972, the medical school applied for its first Financial Distress Grant to meet its operating deficit and to decrease substantial projected tuition increases.

When the school first applied for a Financial Distress Grant, it cited a number of significant problems:

- State or state-like financial assistance was not available to the school.
- The medical school building was overcrowded and inefficient.
- Expansion of educational programs and research activities could not be accomplished until a new facility was completed.
- Access to research funds was limited because the school's overall financial position required that only those research grants covering both direct and indirect costs be sought.

- The school lacked a comprehensive budgeting and financial planning system and the personnel to create and implement such a system.

OBJECTIVES OF THE GRANTS

Beginning in fiscal 1972, the school applied for and received three consecutive years of grants that totalled about \$5.6 million, or 15 to 20 per cent of the operating expenditures over that period. The objectives of the Financial Distress Grants were to provide the medical school with funding to meet its annual deficits, while it took a series of steps to improve its financial management and to minimize the need for radical tuition increases. The school focused its efforts on the need to renovate existing facilities, to build new facilities, to expand the practice plan into a major source of income, to implement an improved budgeting and financial planning system, and to continue to seek funding from governmental agencies.

ACTIONS TAKEN BY THE SCHOOL

The school undertook a number of actions designed to improve its financial position. These actions varied in their impact on the school:

- Major impact: increases in tuition, and improvements in management structure and personnel
- Moderate impact: efforts to increase clinical practice plan income, controls on positions and salaries, and efforts to obtain permanent state-like support
- Minor or no impact: changes in curriculum, and internal cost studies.

The various actions, each of which is defined and detailed in the sections that follow, have been categorized in terms of their "success" in improving the school's financial position.

Major Impact

The actions that had a major impact on the school's financial position are discussed in the paragraphs that follow.

Increases in tuition. Since the early 1970s, tuition at the school has significantly increased and has proven to be a major contributor to the school's total operating budget. The school now has one of the highest tuitions of any medical school in the country. In fiscal 1971 (the year before the first Financial Distress Grant was received), tuition was \$2,000 and offered approximately \$900,000 in income to the school. In fiscal 1972, the school introduced a staggered tuition schedule, increasing the tuition by 25 per cent for the entering class and by 15 per cent for the other classes.

Additional increases were made in each succeeding year, with staggered tuition schedules also used in 1973, 1977, 1978, and 1979. Over the 1971-1979 period, tuition increased by an average of 350 per cent (more for first- and second-year students, less for third- and fourth-year students). The following table shows how the tuition levels were increased by class (figures are expressed as percentages of the 1971 tuition):

<u>Fiscal Year</u>	<u>Class Year</u>			
	<u>First</u>	<u>Second</u>	<u>Third</u>	<u>Fourth</u>
1971	100%	100%	100%	100%
1972	125	115	115	115
1973	150	130	130	130
1974	150	150	150	150
1975	160	160	160	160
1976	250	250	250	250
1977	350	275	275	275
1978	450	375	300	300
1979	590	480	405	325

Total tuition income increased from about \$900,000 in fiscal 1971 to almost \$5.5 million in fiscal 1979; about 30 per cent of the \$4.6 million increase was attributable to an enrollment increase from approximately 450 to 600 students during this period.

As shown in the following table, tuition income increased from nearly 10 per cent to 26 per cent of the school's total operating budget during this period.

<u>Fiscal Year</u>	<u>Tuition Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1971	\$0.9	10%
1973	1.4	12
1975	1.9	12
1977	3.5	19
1979	5.5	26

The tuition increases have helped the school financially, and early concerns regarding the effect on the student mix have not materialized. School administrators do not perceive the tuition increases as having caused a shift in the socioeconomic mix of the students.

Improvements in management structure and personnel. To address the financial planning and facilities issues faced by the school during the early 1970s, a number of changes were made in the school's management processes. The school developed new personnel manuals and policies, revised its wage and salary program, updated its budgeting system, and revised its budgeting review process. The budgetary reforms were particularly useful to the medical school because they provided school administrators with the financial data needed for sound decision-making and assisted in the process of resource allocation among programs at the medical school.

In 1972, the medical center reorganized its management structure to ensure continuity of effort among its three component parts: the medical school, the hospital, and the clinical practice plan. Under the new organization, the vice president of the medical center directed all three functions. Reporting to the vice president were three deans, for administration, clinical affairs, and academic affairs. This new structure facilitated a unified effort across functions and coordination in resource allocation.

While reorganizing, the medical center brought a group of new personnel into the medical center administrative structure. These individuals were responsible for implementing the budgetary and financial reforms detailed previously. These managerial and structural changes were felt to have broadened the knowledge and the administrative capabilities of management at the school and in so doing, to have facilitated the effective direction of long-range financial planning and control for the medical center.

Moderate Impact

The actions of the school that had moderate impact on its financial position are discussed in the paragraphs that follow.

Efforts to increase clinical practice plan income. Income from the clinical practice plan is unrelated to the medical school in any measurable fashion, though it is an important contributor to the financial picture of the medical center. Until 1967, the medical school had no full-time clinical faculty members. The evolution of the practice plan began in 1968, with approximately 70 faculty members representing all departments except anesthesiology, pathology and radiology. The policy was established that the group practice would carry all of its expenses. The net revenues from each faculty member's practice efforts (less the full cost of the practice) were then split among the faculty members, the department, and the dean. The faculty member received an established percentage (currently 15 per cent) of the net revenue produced, which was treated as bonus income for the faculty member. The residual fund was then split equally between the department and an overall fund account.

Departmental funds were used for equipment, support personnel, and general departmental support. These funds could not, however, be used to pay salaries or bonuses to faculty members. Any expenditures from the departmental funds were subject to approval of the dean for administration. The fund account portion would be used at year end, as required to support operating deficits.

This system of managing practice plan funds is still in effect and has been of benefit to the medical school:

- The income stream helps the school to meet its cash-flow requirements.
- The accumulated fund balance under the dean's control serves as a quasi-endowment which generates income on its own and can be used, as necessary, to cover deficits.

The development and structuring of the practice plan provided a substantial source of funding, although, according to school administrators, practice plan income is not related to the school in any directly measurable fashion.

Controls on positions and salaries. In the early 1970s, the school administrators adopted a "no growth" philosophy which has guided position and salary decisions. From 1971 through 1979, the school maintained a constant ratio of faculty to students. The increases in the school's full-time, on campus faculty (from 163 in 1971, to 186 in 1975, and 216 in 1979) were fully equivalent to increases in the number of students. Salaries at the school are assessed by school administrators as being below regional averages for basic sciences faculty, but competitive in the nonacademic areas. The clinical faculty members,

because they receive additional compensation through the practice plan, are paid competitively within the region. Increases to base salaries are granted within guidelines established by the university. Each year the university specifies the average salary increase permitted; the school is then allowed to divide this pool of increases among its faculty members as it deems appropriate.

Efforts to obtain permanent state-like support. Throughout the early 1970s, the school sought federal or state-like governmental support. Although state-like funds were authorized under a 1970 act, the money was never appropriated. Instead, from 1972 through 1974, the school received Financial Distress Grants. In 1974, the school joined a successful lobbying effort on behalf of an extension of the 1970 legislation. Between fiscal 1975 and 1978, the school received a capitation award of \$5,000 per student, up to a maximum of 600 students. Funds received from the government through this program proved useful to the school, and represented a substantial portion of the school's total operating budget between 1975 and 1977, as shown in the table below:

<u>Fiscal Year</u>	<u>Total Funding (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1975	\$2.7	17%
1976	3.0	16
1977	2.2	12
1978	1.0	5
1979	0.0	0

Minor Or No Impact

The actions that had a minor or no impact on the school's financial position are discussed in the paragraphs that follow.

Changes in curriculum. In its financial distress application, the school mentioned the possibility of implementing a trimester program to increase the enrollment level and raise tuition and capitation income. For the same reasons, consideration was given to a dual-entry program and a doubling of the size of the freshman class. Neither of these ideas was ever implemented, because each would have required significant increases in the number of faculty at the medical school.

Another curriculum-related action that was contemplated in the first financial distress application was the establishment of a career military program, designed to train military doctors. Although the school does educate a number of commissioned military officers, these individuals pay normal tuition. A special program was never developed because the school determined that there were no additional financial benefits of establishing and running such a program.

Internal cost studies. Throughout the grant period, the school conducted internal cost studies to monitor their own costs and to compare their levels of expenses to the expenses of other medical schools. In addition, when the medical school relocated to its new facility in the early 1970s, a number of cost studies, primarily focusing on energy conservation, were conducted by medical school administrators. These studies were of general assistance in identifying areas in which expenses could be reduced.

SUMMARY

The three years of financial distress funding provided the school with short-term financial support which enabled it to offset its operating deficits and delay the substantial tuition increases that were ultimately put into effect. During this period, the school was able to reorganize its management structure, to acquire key personnel, and to put into place a series of sound financial policies and procedures that have helped throughout the 1970s.

SCHOOL E

This section discusses the involvement of School E in the Financial Distress Grant Program. It includes discussions on the background of the school, its objectives in seeking the financial distress grants, the actions it has taken to alleviate financial distress, and a summary of its success in achieving its objectives.

BACKGROUND

School E is a four-year medical school that is part of a private university. The school has a class size of approximately 150 and is part of a medical center that also includes a wholly owned hospital and clinic. As is typical of medical schools, it has affiliations with a number of other hospitals and medical facilities.

The school incurred annual operating deficits for each of the ten years before it first applied for financial distress funding. The deficits, which totalled \$3.1 million between 1969 and 1971 (9 per cent of total operating expenditures during that period), were subsidized by the parent university through its unrestricted endowment and other sources. In 1970, however, the university itself began to operate at a deficit, and in 1972 notified the medical school that it was no longer willing or able to fund its deficits. Therefore, the medical school applied for the first of a series of consecutive Financial Distress Grants to meet its operating deficit, and to avoid taking severe actions that could have an adverse effect on program quality.

When the school first applied for a Financial Distress Grant, it cited a number of significant problems:

- It had no clinical facilities of its own; the physical plant was outdated, and the research facilities were inadequate.
- It provided 50 per cent of the patient care at a local welfare hospital that served as its primary teaching facility.
- It received inadequate reimbursement for services rendered to the hospital, however, and the relationship constituted a substantial drain on its financial resources.
- It had difficulty in attracting qualified faculty members, primarily because of inadequate facilities and salaries that were lower than national and regional averages.

OBJECTIVE OF THE GRANTS

The objective of the Financial Distress Grants was to provide the medical school with funding to meet its operating deficit, while it took a series of steps to alleviate its financial difficulties over the longer term. Over five consecutive years, the school applied for and received grants totalling \$3.5 million, or 4 per cent of the operating expenditures over that period.

The school focused its efforts on the need to renovate existing facilities, to build new clinical facilities, to expand the practice plan into a major source of income, to obtain funding for services at the local welfare hospital, and to obtain other, nonfederal sources of income. The direction and objectives of the school changed very little during the grant years, although the timetable by which the objectives were to be accomplished was updated annually.

ACTIONS TAKEN BY THE SCHOOL

The school undertook a number of actions designed to improve its financial position. The impact of these actions varied:

- Major impact: development of a strong plan to increase practice income, construction of hospital and clinic and improvements in facilities, changes in affiliation agreements, and increase in tuition and fees
- Moderate impact: control of school contributions to faculty salaries, and control of faculty and staff positions
- Minor or no impact: efforts to obtain state aid, changes in facilities maintenance, efforts to increase contributions, improvements in management structure, internal cost studies, and cost recovery involving sponsored programs.

The various actions, each of which is defined and detailed in the sections that follow, have been categorized in terms of their "success" in alleviating the school's financial distress.

Major Impact

The actions that had a major impact on the school's financial position are discussed in the paragraphs that follow.

Development of a strong plan to increase practice income. The largest contributor to the operating budget of the school is the clinical practice plan. That plan, as it is now structured, evolved over a six-year period ending in 1976, and has emerged as a major factor in the school's financial picture. Development of a strong practice plan involved two steps: first, to design the concept and logistics of a strong plan; and second, to implement the plan.

In the late 1960s, the plan involved less than 30 physicians, each having a different arrangement with the school that governed seeing outside patients and retaining outside earnings. The structure of the plan was altered in the early 1970s to incorporate the following provisions:

- All geographic, full-time clinical faculty members were converted to a strictly full-time basis.
- All full-time faculty members were required to participate in the practice plan, with all their professional income controlled by the school. Thus, all professional income generated by faculty members, including clinic income, was made subject to the practice plan rules; only awards and prizes were excepted.
- A central business office was established for billing, collecting and allocating practice plan income among plan participants, the medical center, and the clinical departments of the medical school, and for administering the practice plan.
- The amount of money that the operating departments could retain for their own use was governed by the volume of billings for service. Because the dean shared in the earnings of the faculty, the school was able to assist basic science departments and other clinical departments that generated volumes of billings.

Throughout the early 1970s, departments were phased into the practice plan so that, by 1975, all medical school departments participated in the plan. The development and structuring of the clinical practice plan provided a substantial source of funding for the school. As shown in the following table, the practice plan (after cost of practice) generated approximately \$7 million of revenues in 1979; after payment of salaries and incentives, the accumulated equity in the practice plan was approximately \$2.1 million.

<u>Fiscal Year</u>	<u>Revenues (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1971	0	0
1975	\$1.1	7%
1979	7.0	28

The strict policies established by the school's medical center administrators were successful in generating and retaining income, with few negative side effects. The plan was established with the support of the faculty, and fewer than ten faculty members left when the plan restrictions were imposed. School administrators report that the quality and depth of the faculty have never been better.

Construction of hospital and clinic and improvements in facilities. From 1972 through 1976, the school undertook an improvement program that included construction of a 300-bed medical center hospital and a clinic, and major renovation of existing medical school facilities. Construction of the medical center hospital and clinic (which cost \$43 million and was funded by a private bond issue) was initiated in 1973. The hospital owned 60 beds in late 1976. Since that time, the hospital has been expanded to 200 beds. The hospital has provided a controlled, wholly owned facility where physicians from the medical school could practice, has fostered the development of the strictly full-time faculty, has helped to relate practice activities to the educational program, and has yielded additional revenue.

As another teaching facility for the medical school, the hospital and clinic paid the medical school \$750,000 in fiscal 1979 for services and for the administration and teaching of interns and residents; this compares to no funding from this source in fiscal 1976 and prior years. In addition, the hospital shares in the general and administration expenses of the university and of the medical school. The school estimates that its share of university expenses is reduced by \$100,000 to \$150,000, and that it receives approximately \$250,000 to help support certain dual positions in administration, planning, development, and other areas.

The renovation of the medical school, which cost \$11 million and was 80 per cent federally funded, was completed in 1980. The primary financial benefits are expected to come from more efficient utilization of space and from reduced utility costs (through improvements in the energy management system).

Changes in affiliation agreements. The school has an affiliation with a 1,000-bed hospital that is owned and operated by the state for welfare patients. Under this arrangement, the school is responsible for 50 per cent of the medical staff and is, therefore, significantly involved in providing medical education and services. While the clinical resources at this hospital have always been of substantial benefit to the school, the arrangement for financial reimbursement had been unfavorable.

Prior to fiscal 1977, hospital payments to the school were limited to Part A Medicaid services for the supervision of interns and residents. This payment amounted to between \$250,000 and \$300,000 annually through fiscal 1977. In 1978, the school appealed to the state government for additional recovery of costs. This effort yielded a formal agreement regarding affiliation, with a contract for services that expanded Part A reimbursements to \$580,000 in 1979 and \$1,015,000 (agreed to) in 1980.

In addition, the agreement yielded payment to the school for diagnostic and therapeutic services offered by the medical school's staff and other professional nonpatient care services, including program administration and direction. Together these amounted to another \$1.2 million in 1979, which was used to support faculty salaries. The revenue from the affiliation arrangement increased from \$135,000 in 1971 and \$257,000 in 1975, to an estimated \$1.8 million in 1979.

Increase in tuition and fees. The school significantly increased its tuition, which proved to be an important factor in improving its financial position. In fiscal 1972 (the year before the first Financial Distress Grant was received), tuition was approximately \$2,000 and provided approximately \$1.2 million of income to the school. Moderate tuition increases of 5 per cent to 8 per cent annually were then made in 1972 through 1975, followed by significant changes in tuition in subsequent years. The following table shows these tuition increases expressed as a percentage of 1971 tuition:

<u>Fiscal Year</u>	<u>Resident</u>	<u>Nonresident</u>
1971	100%	100%
1973	114	114
1975	124	124
1977	167	190
1979	248	357

Tuition increased from 1976 to 1979 by 35 per cent, 0 per cent, 34 per cent and 11 per cent; thus, by 1979, tuition for state residents was more than two and one-half times the 1971 level. In addition, the school initiated a nonresident

tuition differential of 14 per cent in 1977 and increased it to 44 per cent in 1979. Therefore, nonresident tuition in 1979 was three and one-half times greater than its 1971 level.

With no appreciable change in class size over the eight-year period from 1971 to 1979, total tuition income increased to \$3.4 million, or about triple the amount of eight years earlier. As shown in the following table, the tuition income increased over this period from 9 per cent to 14 per cent of the school's total operating budget:

<u>Fiscal Year</u>	<u>Tuition Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1971	\$1.2	9%
1975	1.6	10
1979	3.4	14

While the tuition increases have helped the school financially, there has been some concern within the administration whether tuition can be raised higher without losing students to state-supported medical schools that have lower tuitions. School officials indicate that some loss has already occurred.

Moderate Impact

The actions of the school that had a moderate impact on its financial position are discussed below.

Control of school contribution to faculty salaries. The school took several actions related to the practice plan that controlled the school's contribution to faculty salaries:

- It established base salary ranges by professional rank, with additional earnings available only through the practice plan.
- It established a policy that the clinical faculty members were expected to "earn" salary increases through the practice plan. This policy provided incentives for the faculty to generate additional billings for the plan and surpass their quotas. Because the plan grew in volume, the school was able to achieve the regional median, and later, the national, private-school median for salaries. While the salaries of clinical faculty members were increased every year, only twice in ten years (once by 3 per cent and once by 5 per cent) were the increases funded by the school. As a result of this approach, the university's contribution to clinical faculty salaries averaged less than 20 per cent of faculty members' income.

- All salary increases were limited to the university guidelines, which ranged from 3 per cent to 8 per cent annually. In addition, special upgradings were made to achieve national averages, with this funding being provided by the practice plan.

Control of faculty and staff positions. Beginning in 1972, the school imposed a series of restrictions on the number of faculty and staff positions:

- Freezing the number of staff positions
- Eliminating 40 nontenured faculty positions (many of which were in another school within the medical center) for which grant-supported funding had expired
- Freezing the number of faculty positions in the basic sciences (except where funds were made available under sponsored programs)
- Allowing growth in the number of clinical sciences positions only when such positions would be supported by practice plan revenues.

Therefore, there was little change in the number of staff positions over the 1971-1979 period. The number of faculty was reduced in the mid-1970s from approximately 250 to 200. During the late 1970s, the size of the faculty increased to approximately 250. This shift allowed the school to reassess its faculty requirements and restructure the faculty mix to conform with the new program. Class size did not change over this period, and the use of controls appears to have avoided additional costs rather than reducing existing ones.

Minor Or No Impact

The actions that had a minor impact or no impact on the school's financial position are discussed in the paragraphs that follow.

Efforts to obtain state aid. The school was successful in conducting a campaign for state aid to private medical education. This effort led to state capitation arrangements for in-state residents that provide income to the school. In 1979, the school received approximately \$620,000 from a state that has limited financial resources. Prior to 1973, no state funding was provided.

In 1973, however, the state passed a law granting capitation funding to the school and encouraging the enrollment of state residents. The capitation formula furnishes \$5,000 of state support for the 97th and each subsequent student

enrolled in the medical school, up to a maximum of \$625,000. The amount of state capitation aid received by the school is shown in the following table:

<u>Fiscal Year</u>	<u>Revenues (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1971	0	0
1975	\$0.5	3%
1979	0.6	2

Under the school's current tuition schedule, an additional \$2,300 is charged for out-of-state students. Therefore, the \$5,000 capitation for in-state students provides an incentive to enroll state residents. According to school administrators, approximately 40 per cent of the students in 1979 were in-state.

Changes in facilities maintenance. To contain costs, the school established an in-house staff to perform repair, alteration, and renovation services previously performed by outside contractors. This skilled crew, of approximately 35, was established between 1971 and 1975. The crew performs services valued at approximately \$800,000, all of which is billed to the departments that use the services. The "charge-back" arrangement is intended to encourage the departments to control their expenditures and to establish priorities for service requests. The savings from this practice cannot be readily determined, although it is likely that outside contracting would be more costly.

Efforts to increase contributions. The school has been able to increase its alumni contributions and gifts for current operations. The school took a number of steps to improve its ability to obtain contributions:

- A separate alumni program for the medical center was established in 1972, which included the establishment of organizational units, receipt of dues, annual solicitation of gifts, and coordination of trips and other services to alumni.
- A development office was established within the medical center in 1974 and given the responsibility for all fund-raising activities, including the maintenance of contacts originally established during the construction of the medical center hospital and clinic.

Gifts for capital improvement contributed substantially to the school's construction program. As shown in the following table, gift income for current operations increased significantly over the 1971-1979 period, with the rate of the increase accelerating in recent years:

<u>Fiscal Year</u>	<u>Gift Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1971	\$0.2	1%
1973	0.2	1
1975	0.2	1
1977	0.3	1
1979	0.5	2

Improvements in management structure. To address the financial planning and facilities issues faced by the school during the early 1970s, a number of changes were made in the school's organizational structure. First, the medical school was reorganized under a newly created medical center encompassing the school and the new hospital. Second, the positions of vice president - health affairs and assistant vice president - health affairs and the office of planning were created. These managerial and structural changes were perceived to have broadened the knowledge and the administrative capabilities of management at the school and, in so doing, to have facilitated the effective direction of long-range planning for financial recovery, the building program, and the restructuring of the clinical practice plan.

Internal cost studies. The school completed a study in 1972 of its costs by functional area for fiscal 1971. This study, under the sponsorship of the Bureau of Health Manpower Education of the former Department of Health, Education, and Welfare and in conjunction with the Association of American Medical Colleges, defined expenditures and income by detailed functional areas. It reviewed the allocation of faculty time to specific functions (such as services provided to the affiliated welfare hospital) and provided a basis for subsequent identification of the costs associated with offering each of these services. This study served as a benchmark for later updates.

The study was of assistance to the school because it helped management focus on areas in which cost improvements were possible, and provided data to substantiate cost-retrieval measures. It had three primary results, as follows:

- Gave school administrators a firmer understanding of the costs of operating the medical school and of the funds allocation process

- Provided the basis for the cost data that were presented to state officials to justify cost recovery from the affiliation with the state-run welfare hospital
- Promoted recognition of specific areas in which effort exceeded remuneration and, as a management tool, assisted in making decisions whether the school should stay in, expand, or contract particular programs.

The timing of the study was appropriate because it provided essential data regarding financial pressures to the school's new leaders.

Cost recovery involving sponsored programs. Controls imposed on grant funds have proven effective in ensuring that the indirect costs associated with the grants would be identified and covered. These measures were initiated as a result of internal cost studies conducted by the school, which indicated a need to improve the recording and recovery of indirect costs associated with research grants and other programs. To accomplish this, the school began to levy a 15 per cent overhead fee on all income received from nongovernment research grants and programs (such as drug studies for industry). The policy of a levy had been in effect for many years but had not been meaningfully enforced. Enforcement evolved to the point where this source now yields \$250,000 to \$300,000 annually.

SUMMARY

The five years of financial distress funding offered the school short-term financial support while it took steps to address its underlying, chronic financial problems. These steps have enabled the school to attain financial stability.

- The school operating deficit was reduced to only 0.1 per cent of the operating budget in 1979, compared with a deficit of approximately 6.0 per cent in 1975 and approximately 9.0 per cent in 1971.
- The school has been able to resolve the major problems that it faced in earlier years and to offer a basis for a sound financial position.
- The school built its own hospital and clinic, renovated its own school facilities, obtained more favorable affiliation agreement with the state welfare hospital, and instituted a practice plan that yields sufficient funds to attract and maintain qualified faculty as well as funding the faculty and other programs.

Although the school did succeed in achieving its objectives, the financial turnaround took longer than was initially anticipated, and the projected timing for a turnaround in the operating deficit was adjusted annually. For example, the 1972 plan projected a deficit of \$105,000 in 1975, which was revised in the 1973 plan to a deficit of \$1.4 million. A deficit of approximately \$960,000 was actually incurred.

SCHOOL F

This section discusses the involvement of School F in the Financial Distress Grant Program. It incorporates separate discussions on the background of the school, its objectives in seeking the Financial Distress Grants, the actions taken to alleviate financial distress, and a summary of the school's success in achieving its objectives.

BACKGROUND

School F is a four-year medical college that is part of a private university. The school has a class size of approximately 150, and is part of a medical center that also includes the schools of nursing, allied health, and health care administration. The university also owns a teaching hospital. As is typical of medical schools, School F has affiliations with a number of other hospitals and medical facilities.

School F incurred annual operating deficits from 1969 through 1972, which was the year it first applied for financial distress funding. These deficits totalled \$2.6 million (or 9 per cent of total operating expenditures). The parent university subsidized the deficits until 1972 primarily through its funds functioning as endowment. In fiscal 1972, the university itself began to operate at a deficit and notified the medical school that its ability to fund the medical school deficit was limited. The university launched a unified campaign to balance its budget for fiscal 1973. In turn, the medical school applied for its first Financial Distress Grant to meet its operating deficit, and to avoid taking severe actions that could have an adverse impact on the quality of its program.

When the school first applied for a Financial Distress Grant, it cited a number of significant problems, as follows:

- The school had limited clinical facilities, the physical plant was outdated, and the research facilities were inadequate.
- The school received inadequate reimbursement for services rendered to affiliate hospitals.
- The school was required to increase enrollments to qualify for educational assistance, thereby placing pressure on the medical school because it caused increased costs for faculty, support personnel, and equipment.

- The school had difficulty attracting qualified faculty members, primarily because the salaries offered were lower than national and regional averages.

OBJECTIVE OF THE GRANTS

The objective of the Financial Distress Grants was to provide the medical school with funding to meet its operating deficit, while it took a series of steps to alleviate its financial difficulties over the longer term. In fiscal 1972 and 1973, the school applied for and received grants of approximately \$1 million, or 6 per cent of the operating expenditures over that period.

The school focused its efforts on the need to renovate or build facilities, to turn the faculty practice plan into a major source of income, to obtain reimbursements for services rendered to affiliated hospitals, and to secure other nonfederal sources of funding.

ACTIONS TAKEN BY THE SCHOOL

The school undertook a number of actions designed to improve its financial position. These actions varied in the importance of their impact on the school.

- Major impact: increase in clinical practice plan income, improvements in facilities, changes in affiliation relationships, and increase in tuition
- Moderate impact: efforts to increase contributions, control of faculty and staff salaries, and control of faculty and staff positions
- Minor or no impact: improvement in management structure, internal cost studies, efforts to secure grants from outside agencies, and restrictions on purchases and equipment acquisition.

The various actions, each of which is defined and detailed in the sections that follow, have been categorized in terms of their "success" in alleviating the school's financial distress.

Major Impact

The actions that had a major impact on the school's financial position are discussed in the paragraphs that follow.

Development of a strong plan to increase practice income. The most significant contributor to the operating budget of the school is the clinical practice plan. This plan, which evolved over a six-year period from 1972 through 1978, has emerged as the single most important factor in the school's financial picture.

In the late 1960s, the policies and procedures for generating faculty patient-care revenues were handled by the clinical departments. Each department approached the issue differently, establishing varying policies concerning retention of income, types of income covered, and use of the departmental portion of the income. Billing procedures were also decentralized during the late 1960s. The structure of the plan was altered in 1971 and 1972 to incorporate the following provisions:

- All clinical faculty members were to move to a strictly full-time basis.
- All full-time clinical faculty members would become plan participants, with their patient-care income controlled by the school.
- University designated funds were established for all departments to handle the revenues and expenses associated with the practice plan.
- A centralized billing and financial information service for the clinical practice plan was established subsequently, and the departments were brought under the service on an orderly, phased basis.
- A 15 per cent dean's fund was drawn from the plan earnings to assist in underwriting the general operating expenses of the school. For example, the dean's fund has supported salaries of department chairpersons and central administrative personnel, provided general program support for new or existing departments, and furnished needed capital for space renovation and equipment to attract well-qualified faculty.

- A policy was established whereby all practice plan revenues were deposited with the parent university, thus contributing to the university's cash flow. No charges to the departmental accounts are permitted, however, without the departmental chairperson's approval.
- A clinical faculty incentive pool was established, on a formula basis, which results each year in a sum of money that the department head (with the dean's approval) may distribute to the individual faculty as additional compensation. Allocations to faculty members engaged primarily in teaching or research were permitted, provided that some part of their salaries were recovered from a grant or restricted fund.

The development of the clinical practice plan provided a substantial source of funding for the school. As shown in the following table, the practice plan generated approximately \$8 million of gross revenues in 1979:

<u>Fiscal Year</u>	<u>Gross Revenues (Millions)</u>
1976	\$4.5
1977	5.9
1978	6.7
1979	8.1

Construction of research facilities and ambulatory care building and improvements in other facilities. In the late 1960s and early 1970s, the school undertook an improvement program that involved construction of a research wing of the medical school, construction of an ambulatory care building, and a series of renovations to the medical center complex.

The construction of the research wing of the medical school and the renovations to the medical center complex were made to maintain or enhance academic programs. These construction projects were not conducted for the purpose of affecting the school's financial situation directly, although by preventing a reduction in program quality, they may have indirectly had such an effect.

The ambulatory care building was initiated in 1974 and financed through a mortgage to its owners, a redevelopment corporation wholly owned by the university. Since that time, the building has provided a controlled facility through which the faculty can offer ambulatory services, which they consider

an essential part of total patient care. The ambulatory care building also has helped to relate practice activities to the educational program and, to a limited extent, to provide additional revenue. The faculty currently handle approximately 75,000 patient visits annually in the ambulatory care facility.

Changes in affiliation relationships. In the early 1970s, the school increased its efforts to improve cost recovery from its broad network of affiliated hospitals. Affiliations had been established and managed unofficially, without contractual relationships between the hospitals and the medical school. There were also coordinative problems with the affiliates, in that all record-keeping was done by the departments and varied significantly in the level of detail and accuracy.

In 1973, the medical school recruited an associate dean who has devoted major efforts to making the school's affiliation relationships more consistent and reaching formal, comprehensive agreements with the affiliates. Since 1973, the school has been successful in formalizing the affiliation agreements. Certain of these agreements now provide for the affiliated hospitals to pay 50 per cent or more of all direct costs of the services provided. Some departments of the medical school are heavily funded by their affiliates and, in fact, their current contracts make these programs possible.

Increase in tuition. The school significantly increased its tuition, and the resulting increase in income has improved its financial position. In fiscal 1971 (the year before the first Financial Distress Grant was received), tuition provided approximately \$1.2 million of income to the school. From 1971 through 1979, total enrollment increased from approximately 520 to 620 and total tuition income increased to \$4.1 million. In nine years, therefore, tuition income had increased by \$2.9 million, or almost triple the 1971 level.

As the following table indicates, moderate tuition increases of 5.5 per cent to 6.25 per cent annually were made in 1972 to 1975; a major increase of 23.0 per cent was made in 1976, followed by a 43.0 per cent increase in 1977, a 16.0 per cent raise in 1978 and a 15.5 per cent increase in 1979. The following table shows these tuition increases expressed as a percentage of 1971 tuition.

<u>Fiscal Year</u>	<u>Tuition</u>
1971	100%
1972	107
1973	113
1974	120
1975	127
1976	156
1977	222
1978	258
1979	298

While the tuition increases have helped the school financially, there is growing concern with the administration that students' decisions in accepting offers to enroll at the school may be adversely affected by current and projected tuition levels. Through 1979, however, the potential negative effects were not manifest.

Moderate Impact

The actions that had a moderate impact on the school's financial position are described in the following paragraphs.

Efforts to increase contributions. The school has increased its income from endowments and gifts for current operations since the early 1970s. Neither of these sources, however, contributes a significant share of the school's operating funds. Endowment income, which had decreased from approximately \$375,000 in 1971 to a low of nearly \$300,000 in 1972, had increased to approximately \$435,000 in 1979. Gift income increased from \$270,000 in 1974 (the first year for which figures are available) to \$345,000 in 1979. Both of these amounts fluctuated somewhat since 1971, but have shown an overall modestly increasing trend.

Control of faculty and staff salaries. The school placed stringent controls on salaries in fiscal 1973, when it froze salaries at the 1972 levels. This move was in response to a universitywide salary freeze, and is estimated to have saved approximately \$75,000. Salary freezes were not implemented after 1973. Salary increases have been closely monitored and have been held to an annual average of approximately 7 per cent since 1973.

Although the school made efforts to save operating funds by tempering salaries, this tactic was not viewed by administrators as being a long-range solution. In fact, school administrators used salary controls as a temporary

measure, recognizing that they would have to catch up after the financial crisis had passed. Currently, salaries at the school approximate the average level for its geographic region according to the annual salary survey conducted by the Association of American Medical Colleges.

Control of faculty and staff positions. Beginning in 1972, the school imposed restrictions on the number of faculty and staff positions by:

- Freezing the number of positions in 1972 and 1973
- Establishing a policy that faculty and staff replacement or recruitment must be approved by the dean, the vice president, and the medical center budget subcommittee.

As a result, increases in the number of staff positions have been held to a minimum over the 1971-1979 period. Concurrently, enrollment increased from 520 in 1971 to 620 in 1979.

Minor Or No Impact

The actions that had a minor impact or no impact on the school's financial position are discussed in the paragraphs that follow.

Improvement in management structure. To implement a number of specialized management and program effectiveness policies, the school recruited an associate dean in 1973. This individual assumed the role of "fire fighter," handling a number of projects and managerial issues, including negotiating the contracts for the affiliations that the medical school maintained with a number of area hospitals. By bringing in this individual, the school broadened the knowledge and administrative capabilities of management.

Internal cost studies. The school completed a program cost study in 1971 of its income and expenditures for fiscal 1970. This study defined expenditures and income by detailed functional areas. It reviewed the allocation of faculty time to specific functions (such as services provided to the affiliated hospitals), and provided a basis for subsequent identification of the costs associated with offering each of these services.

The study helped management focus on areas in which cost improvements were possible, and provided data to substantiate cost-retrieval measures. The study had two primary results, as follows:

- It provided school administrators with a firmer understanding of the costs of operating the medical school and of the funds allocation process.

- It facilitated recognition of specific areas in which costs could be reduced. (For example, it pinpointed high program costs in graduate education and in research programs. The school studied these functions and made a number of improvements in these programs. The financial impact of these changes was not quantified by the school, however.)

Efforts to obtain grants from outside agencies. In fiscal 1972, the school faced cutbacks in its research programs due to the reduction in federal grant funding for research. In areas where federal funding had not been renewed or where full funding was not granted, the university had contributed money to assist the school in carrying out an orderly reduction in the scope of the projects.

In 1972, faculty members were requested to make concerted efforts to obtain grants from outside agencies in order to offset expenditures for research. This policy is still in effect. In the basic sciences areas, efforts to generate grant funding are considered specifically in the faculty annual salary review. Junior faculty members must generate some grant funds, though not necessarily enough to support their full salaries, in order to be considered seriously for a tenured faculty position. During this period, these policies have been generally unsuccessful in generating additional income. The level of government grants and contracts decreased from almost \$6 million in 1972 to \$4.7 million in 1979. Private gifts and contracts were approximately \$750,000 in 1972, decreased to between \$325,000 and \$400,000 from 1974 through 1977, and increased to more than \$800,000 in 1979.

Deferral of purchases and equipment acquisition. In 1971, the dean of the medical school established three rules to control purchases and equipment acquisitions:

- Purchases in excess of \$100 were to be approved by the medical center budget subcommittee
- Added equipment was no longer to be budgeted against non-restricted (general) funds.
- Only obsolete equipment could be replaced and any requirements were to be kept to a minimum.

This policy was in effect only during fiscal 1972, because it was viewed as a cost-deferral rather than as a cost-saving measure. Although this policy helped the school channel resources into more critical areas during 1972, many deferred purchases were made subsequently, and often at higher prices.

SUMMARY

The two years of financial distress funding provided the school with short-term financial support. The actions proposed and taken were effective in reducing the medical school's deficit. In fact, the school has become a net provider of funds to the parent university since the years in which the grants were received. This shift is primarily the result of changes in the clinical practice plan, which generated more than \$8 million of gross revenues in fiscal 1979, and provides an estimated 50 per cent of the school's annual operating budget.

SCHOOL G

This section describes the involvement of School G in the Financial Distress Grant Program. It also presents the background of the school, its objectives in seeking the Financial Distress Grants, the actions taken to alleviate financial distress, and a summary of the success in achieving the objectives.

BACKGROUND

School G is a part of a private university that has a full complement of health professions schools. The medical school has an entering class of about 110 students. Because the school does not have its own hospital, it uses affiliated hospitals for clinical teaching, patient care, and clinical research activities.

The school incurred annual operating deficits in each of the three years before it first applied for financial distress funding. These deficits, which totalled approximately \$1.3 million from 1969 through 1972 (or almost 6 per cent of the total operating expenditures during that period) were subsidized by the parent university, primarily from endowment, interest on income from practice plan funds, and medical school alumni gifts. The university, however, has a small endowment and was itself faced with financial pressures during the 1970s.

At the same time, the school faced an increasing shortage of income to support its activities, because of decreases in federal research and operational support and the overly optimistic projections of federal capitation support. The medical school applied in fiscal 1972 for the first in a series of Financial Distress Grants to meet its operating deficits, allowing time to implement a number of programs to generate additional income for the school and, thereby, to alleviate the financial support demands placed on the university.

When the school first applied for a Financial Distress Grant, it was in the process of upgrading facilities to support its medical school program. Without these improvements, the school felt that it lacked the base to deal with its current and projected deficits. The school was also having difficulty competing with larger, established and more adequately funded institutions in seeking research grants.

OBJECTIVE OF THE GRANTS

The objective of the Financial Distress Grants was to provide the medical school with funding to meet its operating deficits, while it took a series of steps to alleviate its financial difficulties over the longer term. Beginning in fiscal 1972, the school applied for and received five consecutive grants that totalled \$1.9 million, or 4 per cent of the school's operating expenditures from 1972 through 1976.

The school focused its efforts on the need to build additional income sources, including revenues from professional services, to improve its position for extramural grant and contract support, and to divest ownership and operation of the ambulatory care facilities. The direction and objectives of the school changed very little during the grant years, although the timetable by which the objectives were to be accomplished was updated annually.

ACTIONS TAKEN BY THE SCHOOL

School G took a number of actions designed to improve its financial position. These actions, categorized in terms of their success in alleviating the school's financial distress, included:

- Major impact: increase in clinical practice plan volume and income, and increase in tuition
- Moderate impact: encouragement of basic sciences faculty to seek reimbursable teaching opportunities outside the school of medicine, efforts to increase contributions, control of faculty salaries and efforts to secure grants from outside agencies
- Minor or no impact: obtaining capitation support from other states, reduction in nonreimbursed community services, internal cost studies, and efforts to increase federal capitation funding.

Major Impact

The actions that had a major impact on the school's financial position are discussed in the paragraphs that follow.

Increase in clinical practice plan volume and income. The practice plan has undergone two important changes since its inception in 1968. First, the principle was adopted that clinical faculty members must bear some of the overhead or fixed costs of their practice. This principle led to a policy of splitting the amount of collections from the practice on a 50:50 basis with the medical school. The medical school, in turn, allocated 85 per cent of its share of practice plan collections to departmental overhead costs and, to a limited extent, to salary expenses. The remaining 15 per cent of its share (7.5 per cent of the total) was credited to a dean's fund, which was used to subsidize salaries or program costs in areas that were not self-supporting.

Second, modifications were made in the accounting practices that governed the allocation of faculty income. During the early years of the practice plan, faculty members were guaranteed an established minimum salary. This amount was paid directly to the faculty member out of his or her "first earnings," and was not recorded on the books of the university or the practice plan. In the early 1970s, the school established a policy of collecting all of the practice plan funds, depositing them with the university, and then compensating the doctors.

Then, in 1977, the policies were further revised and the faculty plan participants were no longer guaranteed a minimum income from the plan. Instead, the physicians were paid according to the billings or collections they generated through the practice plan. At that time, the proportion of collections distributed to the physician was also decreased from 50 per cent to 40 per cent, in certain departments.

Since the early 1970s, the structure of the plan has incorporated the following provisions:

- The 115 clinical faculty members are on a geographic full-time basis.
- All full-time faculty members were required to participate in the practice plan, with all their professional income controlled by the school.
- A central facility was established for billing and collecting all clinical faculty income, for allocating income among plan participants and the clinical departments of the medical school, and for administering the practice plan.

- The amount of money the operating departments had available for their own use was governed by the volume of the billings for service. (Because the dean shared in the earnings of the departments, the school was able to offer financial assistance to basic science departments and certain clinical departments that generated lower volumes of billings.)

The plan generated \$5.8 million of total income in fiscal 1979, or 33 per cent of the total operating budget. As shown in the table below, this amount compared with \$2.4 million in 1975 and \$851,000 in 1972.

<u>Fiscal Year</u>	<u>Total Practice Plan Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1972	\$0.9	13%
1975	2.4	21
1979	5.8	33

Increasing tuition. The school significantly increased its tuition, and was able to maintain this area as an important source of funds. In fiscal 1971, (the year before the first Financial Distress Grant was received) tuition provided approximately \$800,000 of income to the school. As shown in the table below, tuition increases of 7 per cent to 10 per cent were made annually from 1971 through 1976, and followed by increases of 21 per cent in 1977, 12 per cent in 1978, and 6 per cent in 1979, representing a total increase of 217 per cent over an eight-year period. Taking account of an enrollment increase at the medical school from 330 to 440 students, total tuition income had increased to about triple the level of eight years earlier. Tuition levels shown below are expressed as a percentage of the 1971 tuition.

<u>Fiscal Year</u>	<u>Tuition</u>
1971	100%
1972	111
1973	121
1974	129
1975	142
1976	150
1977	182
1978	204
1979	217

The increased tuition served to stabilize the increases that were occurring in the school's operating budget. As shown in the table below, the tuition contributed between 13 per cent and 17 per cent of income for selected years between fiscal 1971 and fiscal 1979.

<u>Fiscal Year</u>	<u>Tuition Income (Millions)</u>	<u>Per Gent Of Operating Budget</u>
1971	\$0.8	14%
1975	1.5	17
1979	2.3	13

As its current level, the school's tuition is still among the lowest of any of the private medical schools. The university has encouraged the school to keep its tuition low in order to encourage well-qualified students to enter the university for undergraduate training. Since undergraduates from the parent university are given preference for admission to the medical school, this policy appears to benefit the university as a whole, rather than the medical school. Because the medical school's tuition is comparatively low, it represents a potential resource that may be drawn upon in the future to offset financial pressures.

Moderate Impact

The actions that had a moderate impact on the school's financial position are detailed in the following paragraphs.

Encouragement of basic sciences faculty to seek reimbursable teaching opportunities outside the school of medicine. Beginning in 1976, the school emphasized a policy of encouraging the basic sciences faculty to seek teaching opportunities in the other health profession schools (for example, dental, pharmacy, nursing) and in the university's undergraduate arts college. This approach has brought in a gradually increasing income generated through transfers from other schools within the university to the medical school. In 1979, nearly 5,000 student credit hours of instruction had been taught by medical school faculty members to students in other schools or colleges of the university. As a result, the income transferred to the medical school from these programs has increased from \$0 in 1972 to \$156,000 in 1979.

Efforts to increase contributions. The medical school is not allowed to appeal independently to alumni for operational or capital support. As a result, the school is limited to obtaining unsolicited gifts, obtaining approximately \$65,000 of the income from its own \$1.5 million endowment, and sharing in funds generated by universitywide fund-raising campaigns. Two such campaigns have been conducted (one ending in 1972, and another running from 1974 through 1979, which yielded approximately \$7 million for university operations). As shown in the table below, alumni contributions have increased since 1973, but continue to represent a minor portion of the school's total operating budget.

<u>Fiscal Year</u>	<u>Alumni Gifts (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1973	\$0.3	4%
1975	0.4	3
1977	0.5	3
1979	0.6	3

Proceeds from the university's endowment are made available to the medical school to cover operating deficits.

Controls on faculty salaries. The school placed a number of controls on faculty salaries, while it sought to raise salaries to the median level for medical schools (as published by the Association of American Medical Colleges (AAMC) survey). Two types of controls were established, as follows:

- Base salaries for faculty members were increased an average of 5 per cent annually, representing increases that are generally consistent with university policy. Over a five-year period (from fiscal 1976 to fiscal 1980), the increases were 10, 0, 7, 6 and 7 per cent, respectively.
- Any additions to the base salaries of clinical faculty members were expected to be earned through the practice plan. This approach provided incentives for the clinical faculty to generate additional billings for the practice plan.

By imposing salary controls, the school has been able to avoid an undetermined amount of increased costs. Nevertheless, the school recently has fallen behind in its efforts to meet the mean salary published by the AAMC.

Efforts to secure grants from outside agencies. In the early 1970s, the school recognized that it was unsuccessful in competing for grants with larger, established, and better-funded institutions. By fiscal 1972, for example, income from research grants had dropped to approximately \$400,000 (as compared with approximately \$900,000 in fiscal 1967). Because the school had traditionally emphasized patient care (and the production of practice plan income), the emphasis on research was less than other institutions competing for grant funds. This traditional emphasis further restricted its competitive position in the so-called "marketplace" for research funds.

Actions were not taken to increase grants until 1978. At that time, the university formed an office of research assistance to assist the faculty in obtaining grants. This office, under the direction of the dean of the graduate school, provides assistance in submitting applications and maintains an information system. The university's new president (who assumed office in 1978) took a strong position on relating faculty research to promotion and tenure, although the emphasis on research varied among the departments.

Although few actions were taken to increase the level of grants, research grants have increased steadily since the mid-1970s, reaching a total of approximately \$1 million in fiscal 1979. The establishment of the research office occurred too late to have had a significant impact on the increased ability to attract grant funds.

Minor Or No Impact

The actions that had a minor or no impact on the school's financial position are described in the paragraphs that follow.

Obtaining capitation support from other states. School G did not receive any aid from its own state, and assessed the probability of a change in the state's funding of private medical education as remote, or even impossible. This assessment was based on two factors, as follows:

- First, the state, through its own state university, was supporting more entering medical school places per unit of population than any other state in the country.
- Second, the state constitution had been interpreted to prohibit the expenditure of state tax funds to support a religiously affiliated institution, such as School G.

School administrators, therefore, looked outside the state for sources of capitation revenue. The school offered class positions in other states that did not have their own medical schools. In an effort to provide a new and stable source of funding, the school contacted appropriate agencies in four other states. As a result of these efforts, a contract with an adjoining state was initiated for fiscal 1976, and continued to the present.

Under the contractual arrangement, a five-year agreement was reached for the school to accept up to 20 qualified students per class (a maximum of 80 students); in addition, a new five-year agreement was approved recently. Since the capitation program was inaugurated in 1976, there have been steady increases in the number of students enrolled in the capitation program, as shown in the table below:

<u>Fiscal Year</u>	<u>Total Enrollment</u>	<u>Number In Capitation Program</u>
1976	440	7
1977	438	26
1978	446	47
1979	441	67
1980	445	80

The school is reimbursed on a capitation basis that involves a formula of assignable costs. The income from this capitation contract, as shown in the table below, has totalled approximately \$1.2 million over the four-year period, from 1976 through 1979.

<u>Fiscal Year</u>	<u>Per Student</u>	<u>Total (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1976	\$6,900	\$0.1	0.3%
1977	7,180	0.2	1.0
1978	7,790	0.4	2.0
1979	8,760	0.6	3.0

These capitation funds are in addition to the tuition paid by students and, therefore, contribute substantially to the costs of educating students enrolled in the program. Furthermore, students admitted under the capitation program represent approximately 20 per cent of the school's total enrollment.

Some question exists regarding the reliability of this strategy as a long-term source of funds. Changes in a state's perspective or priorities could influence its willingness to fund medical education, or to provide capitation support to a school outside the state. Negotiations with other states for a similar arrangement have not yet been successful. The school has agreed, however, to accept a maximum of ten qualified students annually from an eastern hemisphere country beginning in 1983, with reimbursement on a similar basis to the capitation contract with the neighboring state.

Reduction in nonreimbursed community services. In the mid-1970s, the school serviced a number of indigent patients through its major affiliated hospital and, in addition, offered community service programs that were not essential for the medical school's educational programs. In an effort to control these costs, the school began in 1976 to channel admission of indigent patients to the county hospital. The county hospital closed in fiscal 1978, and the major affiliate of the medical school resumed its high load of medically indigent patients. Nevertheless, the hospital, rather than the school, now bears the cost of serving these patients.

Other community service programs, including an outreach program operated by the school, were not viewed as being essential to the medical school's educational programs. Two programs were eliminated between 1975 and 1977, at a cumulative savings of approximately \$100,000 over a three-year period.

Internal cost studies. As a condition of receiving its last Financial Distress Grant, in 1976, the school conducted a study of its costs for the previous years. This study, which was intended to identify cost-reduction opportunities, encompassed:

- A review of space rental costs in the ambulatory clinic, and the possibility of at least a 10 per cent reduction in occupancy costs
- A detailed study of costs and revenues for the basic sciences program, with the goal of terminating as many as five existing faculty positions
- Establishment of administrative guidelines to permit more rigid control of nonsalary expenses.

While these studies were projected originally to reduce annual expenditures by \$250,000, the actual impact (though it has not been quantified) appears to be less. The following actions were actually taken as a result of the internal cost studies.

- Space was reduced in the old facility, but within a year of the internal cost study the school moved the ambulatory clinic to a new building where it substantially increased its space and its occupancy expense.
- In fiscal 1977, eight positions were eliminated in the basic sciences.
- Administrative guidelines were established concerning travel, memberships, telephone usage, and subscriptions. (These policies are still in effect and save an estimated \$30,000 annually.)

Additional benefits of the cost studies were that they enabled school administrators to better understand the cost structure of the programs and services offered by the medical school, and to focus on areas where costs appeared to be excessive.

Efforts to increase federal capitation funding. The school made presentations to its Congressional delegation over the last several years. These actions, however, coupled with the activities of the AAMC and those of other medical schools, were unsuccessful in achieving the desired levels of capitation support.

Other items. In addition, the school considered:

- The transfer of ownership and operation of the ambulatory or out-patient health care facilities to a separate hospital corporation. (The concept was dropped from further consideration, however, because of concerns regarding whether the separate hospital corporation would include an ambulatory clinic, who would control patient care in the hospital, comparability of personnel policies between the hospital corporation and the medical school, and staff morale)
- The development of a health maintenance organization (HMO) under the joint auspices of the university and a separate hospital corporation. (An extensive feasibility study indicated, however, that the premiums that would need to be charged for a program meeting federal specifications would not have reduced health care costs.)

SUMMARY

The five years of financial distress funding offered the school short-term financial support. The actions proposed and taken were not fully effective in reducing the medical school's deficit, which increased each year from \$350,000 in fiscal 1972 to a peak of \$1.16 million in fiscal 1976, and which still represents approximately 4 per cent of its total operating budget.

It should be noted that throughout the period from 1971 through 1979, the school has defined its financial position (the amount of its deficit) before the application of medical school alumni gifts, endowment income, interest income on funds from the practice plan, or administrative overhead (funds generated by medical school research grants). The actual deficit of the medical school is lower than otherwise stated because these funds are not included in the school's operating income. Under an arrangement with the parent university, each year the medical school's projected deficit is acknowledged by the university, and the university agrees to fund the deficit through its own sources which include the funds listed previously. The Financial Distress Grants allowed the medical school to meet its deficit during a period when the parent university faced its own financial difficulties.

SCHOOL H

This section discusses the involvement of School H in the Financial Distress Grant Program. It includes separate discussions on the background of the school, its objective in seeking a Financial Distress Grant, the actions it has taken to alleviate financial distress, and a summary of its success in achieving its objectives.

BACKGROUND

School H, a four-year medical institution, is part of a public university system. The medical school has a class size of 48. At the time it applied for financial distress assistance, the school offered only a two-year program, although it subsequently converted to a full, four-year curriculum.

The school opened in 1971 as a two-year institution offering a basic sciences program. The school had 48 medical students per class, who, upon completing the program, transferred to third-year programs at degree-granting institutions. The program had been fully accredited by the Joint Liaison Committee on Medical Education (LCME) of the American Medical Association and the Association of American Medical Colleges. In the spring of 1973, the LCME conducted a site visit and later made a series of recommendations involving the school's accreditation. The LCME recommended that:

- The school increase its number of full-time-equivalent faculty from 20 to 30; obtain significant long-term financial support (for example, through increases in state support, private contributions, and tuition and fees); develop a faculty research component; and develop contractual agreements for the transfer of its students
- A single year's accreditation be given to the medical school, and a follow-up visit by the LCME be planned in approximately 12 months.

The school was not in an adequate financial position to respond to those recommendations. Although the school was a part of the statewide university system, the state legislature met once every two years to approve budgetary appropriations. The LCME visit had occurred just after submission of the budget and, as such, the school was not in a position to obtain additional state support for at least the next two years. Accordingly, the school applied for a Financial Distress Grant to fund the implementation of the LCME recommendations in the interim.

OBJECTIVE OF THE GRANT

The objective of the grant was to furnish the medical school with funding needed to implement the LCME recommendations and, thereby, to continue as a fully accredited medical school. The grant was made in order to enable the school to:

- Fund eight full-time-equivalent new faculty positions in fiscal 1974 and 11 positions in fiscal 1975
- Provide interim assistance until increased financial support, particularly from the state, could be obtained.

ACTIONS TAKEN BY THE SCHOOL

The school undertook a number of actions designed to maintain its accreditation and to improve its long-term financial position. These actions varied in their impact on the school:

- Major impact: hiring additional faculty, seeking an increase in state support, and increasing tuition and fees
- Moderate impact: continuing private fund-raising efforts, and developing a research component
- Minor or no impact: developing contractual agreements with other schools.

The various actions, each of which is defined and detailed in the sections that follow, have been categorized in terms of their "success" in alleviating the school's accreditation problems.

Major Impact

The actions that had a major impact on the school's financial position are discussed below.

Addition of faculty. The addition of faculty was important to the school's ability to maintain a full accreditation status. The school was advised by the LCME site visit team to increase its number of full-time-equivalent (FTE) faculty positions from 20 in fiscal 1973 to 30 FTE in fiscal 1975, an increase of

approximately 11 positions. The staffing increases were intended to achieve a ratio of four students for each faculty member and four faculty members in each biomedical science discipline. The Financial Distress Grant was awarded by the former Department of Health, Education, and Welfare to fund this increase in faculty.

The school sought to implement fully the recommended additions to the faculty, and did so within the planned time frame. Recruiting began within six months of the site visit, concurrent with submission of the Financial Distress Grant application. As a result, the faculty was increased to 30 FTE positions by the end of fiscal 1974, and to levels above 30 by fiscal 1975. Financial distress funds were used to fund these positions only in fiscal years 1974 and 1975. Thereafter, other sources of funds, including the sharp increase in state support, were used to fund faculty positions.

Obtaining an increase in state support. In the medical school's first years, the state appropriations for the school had been modest in size. In turn, the school relied primarily on foundations, the Federal Government, and private gifts and bequests to develop its program. From its establishment through fiscal 1973, the school received \$183,000 in state support for operating funds (or 6 per cent of total operating budget from 1969 through 1973) and nothing for capital funds. State support had been intentionally low because legislators disagreed initially on the need for a medical school, and because the university wanted to avoid depleting resources for other educational programs.

Beginning with the 1973 state legislatures, the school was able to obtain significant increases in the level of state support, as summarized in the table below. First, the legislature increased its share to 22 per cent of the total budget in fiscal 1974 and 1975. Then, following the LCME recommendations, the level of state support was increased to \$1.1 million or 65 per cent of the budget in fiscal 1976, and to larger dollar amounts in subsequent years. The present target for state appropriations is approximately 70 per cent of the school's total operating budget.

Increases in state appropriation are as follows:

<u>Fiscal Year</u>	<u>Amount (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1972	\$0.1	3%
1974	0.3	23
1976	1.1	65
1978	1.1	46
1980	2.9	55

Increasing tuition and fees. Tuition has always been a relatively small source of income at the school, primarily because it is a state-supported institution. Tuition was increased, however, to provide a broader base of financial support to the school. As shown in the following table, the tuition was increased by 500 per cent over an eight-year period from 1972 to 1980. In addition, nonresident tuition (applicable to approximately 10 per cent of the students) was increased substantially during the eight-year period. Annual tuition, expressed as a percentage increase over 1972, is as follows:

<u>Fiscal Year</u>	<u>Resident</u>	<u>Nonresident</u>
1972	100%	100%
1974	243	172
1976	385	407
1978	462	698
1980	501	721

As shown in the following table, the tuition income increased over this period from approximately 7 per cent of the school's total operating budget in 1972, to about 15 per cent in 1974, 1976 and 1978:

<u>Fiscal Year</u>	<u>Tuition Income (Millions)</u>	<u>Per Cent Of Operating Budget</u>
1972	\$0.1	7%
1974	0.2	15
1976	0.3	16
1978	0.4	15

Moderate Impact

The actions of the school that had a moderate impact on its financial position are discussed below.

Continuation of private fund-raising efforts. The school has always relied upon private contributions as a major source of funds. As shown in the following table, these contributions provided approximately \$3.4 million, or 35 per cent of the school's operating funds between fiscal 1970 and fiscal 1975:

<u>Source Of Funding</u>	<u>Amount (Millions)</u>	<u>Per Cent Of Operating Budget</u>
Private foundations	\$2.4	24%
Other sources	<u>1.0</u>	<u>11</u>
Total	\$3.4	35%

Contributions also provided approximately \$1.0 million of capital funds between 1970 and 1977.

The school has always coordinated its own fund-raising efforts with various special programs for buildings and certain projects (such as laboratories and equipment). These efforts have been undertaken independently of the rest of the university and, as well, the school has not shared in universitywide fund-raising efforts. The volume of contributions was particularly important in the earlier years when state funding was limited.

Development of research component. As a by-product of expanding the faculty, the school was able to attract persons with the capabilities to secure research contracts. The number of research faculty increased from 16 to 48 between 1972 and 1978, with an emphasis on faculty in the basic sciences. While no special actions were undertaken by the school, the enlarged faculty generated a significantly increased volume of grants, as follows:

<u>Fiscal Year</u>	<u>Volume of Grants</u>
1972	\$ 12,000
1974	85,000
1976	250,000
1978	651,000

These funds, which are treated separately from the operating budget discussed earlier, are used for lab technicians, supplies and equipment, and project maintenance.

Minor Or No Impact

The action that had a minor impact or no impact on the school's accreditation status and financial position is discussed in the following paragraphs.

Developing contractual agreements with other schools. The LCME had recommended the development of such agreements to ensure the orderly transfer of students into third-year programs at degree-granting medical schools. While the school had always been able to place its students in the third-year programs of U.S. medical schools, the recommendation was aimed at the expectations that this type of placement would prove to be more difficult in future years.

The school did not significantly change its approach, though it did develop a few one-year contractual arrangements. All students continued to be placed, primarily because of efforts to maintain contacts with other schools and because of the academic reputation of the school's earlier student transfers. This issue became insignificant when the school converted from a two-year to a four-year program.

SUMMARY

The single year of financial distress funding provided the school with short-term financial support, while it took steps to maintain its accreditation and otherwise address its financial problems. Because these steps were successful, the school was able to achieve all of its objectives. The school was able to maintain its position as a fully accredited institution, and later to convert to a four-year school.

Further, the school required only interim financial assistance to meet the funding demands for fiscal 1974 and fiscal 1975. The level of state support increased substantially and provided continuing funding for the school after fiscal 1975.

IV - ASSESSMENT OF THE ACTIONS TAKEN

This chapter analyzes the actions that have emerged as common among the medical school recipients of Financial Distress Grants. It also sets forth conclusions concerning these common actions.

OVERVIEW

Each medical school that received financial distress funding cited in its grant application a series of actions intended to improve the financial position of the school. These actions were reviewed previously on a school-by-school basis. In this chapter, the actions common to a number of the schools will be analyzed individually, focusing on the effect of each specific action. Once again, direct comparisons among the schools are discouraged, as each school operated within a unique environment and an individual set of circumstances.

Two measurements will be employed to evaluate each action: commonality and impact. Commonality indicates the number of schools that took a particular action, or the extent to which an action was common among the schools studied. The impact measurement gauges the extent to which a given action improved the financial position of the schools in which it was taken.

The actions taken by the medical schools are presented in Exhibit IV-1, in a matrix that indicates the commonality of the actions. As shown in the exhibit, 20 different actions were taken by the eight medical schools. The actions with the highest degree of commonality (that is, taken by more than four of the eight schools) include: increasing tuition, controlling salaries and positions, conducting internal cost studies, increasing practice plan income, obtaining or increasing state or state-like aid, revising management structure or personnel, and increasing contributions.

Exhibit IV-2 presents the classifications used throughout Chapter III to sort the actions taken by the medical schools as having a major, moderate, or minor or no impact.

Health Resources Administration

COMMONALITY OF ACTIONS TAKEN BY RECIPIENTS
OF FINANCIAL DISTRESS GRANTS

Action Taken	MEDICAL SCHOOLS								Total Number Of Schools
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	
Increase Tuition	X	X	X	X	X	X	X	X	8
Control Salaries/Positions	X	X	X	X	X	X	X		7
Conduct Internal Cost Studies	X	X	X	X	X	X	X		7
Increase Practice Plan Income		X	X	X	X	X	X		6
Obtain/Increase State or State-Like Aid		X	X	X	X		X	X	6
Change Management Structure/Personnel		X	X	X	X	X			5
Increase Contributions	X	X	X			X	X		5
Change Affiliation Relationship(s)		X			X	X			3
Relocate/Construct Facilities	X				X	X			3
Secure Grants						X	X	X	3
Recover Costs On Sponsored Research		X			X				2
Increase Federal Funding	X						X		2
Obtain External Funding Source	X								1
Improve Facilities Maintenance/Management			X		X				1
Restrict Purchases and Equipment						X			1
Reduce Non-Reimbursed Services							X		1
Encourage Basic Science Faculty To Seek Reimbursable Time Outside School							X		1
Hire Faculty								X	1
Develop Research Component								X	1
Develop Contractual Agreements With Other Schools To Accept Graduates								X	1

Health Resources Administration

**IMPACT OF ACTIONS TAKEN BY
RECIPIENTS OF FINANCIAL DISTRESS GRANTS**

<u>Action</u>	<u>Levels of Impact on Medical Schools(a)</u>		
	<u>Major</u>	<u>Moderate</u>	<u>Minor Or No</u>
Increase Tuition	ABCDEFGH		
Increase Practice Plan Income	BCEFG	D	A
Control Salaries/Positions		ABDEFG	C
Change Affiliation Relationship	BEF		
Relocate/Construct Facilities	AEF		
Obtain/Increase State or State-Like Aid	AH	CD	BEG
Change Management Structure/Personnel	D	BC	EF
Conduct Internal Cost Studies		AC	BDEFG
Increase Contributions		FG	ABC
Secure Grants		GH	F
Increase Federal Funding	A		G
Obtain External Funding Source	A		
Hire Faculty	H		
Encourage Basic Science			
Faculty to Seek Reimbursable			
Time Outside School		G	
Develop Research Component		H	
Improve Facilities Management			CE
Recover Costs On Sponsored Research			BE
Restrict Purchases And Equipment			F
Reduce Non-Reimbursed Community			
Services			G
Develop Contractual Agreements With			
Other Schools to Accept Graduates			H

(a) The medical schools are identified by the alphabetic codes A through H, as they were in Chapter III of this report.

As shown in the exhibits, revenue-producing actions were more commonly employed and had more impact on the financial performance of the schools than did cost-control measures. Six of the ten actions that were most commonly taken by the schools and that had the most major impact were actions intended specifically to increase revenues. These revenue-producing measures include: increasing tuition, increasing practice plan income, changing affiliation relationship(s), obtaining or increasing state(like) aid, increasing contributions and securing grants. By contrast, only two of the top ten actions were focused on controlling costs: controlling salaries and positions and conducting internal cost studies.

In the paragraphs that follow, each of the ten actions that were most commonly taken or that had the greatest impact on the financial performance of the medical schools will be discussed individually. The other actions will then be treated collectively.

Increase in tuition. Tuition increases were implemented by all eight of the medical schools studied. Between 1971 and 1979, tuition increases at these schools ranged from a low of approximately 220 per cent to more than 700 per cent, with an average increase of almost 400 per cent.

At all of the eight schools, increases in tuition provided a major contribution to the operating budget of the school. Furthermore, the proportion of the total operating budget gathered through tuition increased substantially during the 1970s. In five of the schools, tuition contributed more than twice as much, on a percentage basis, to the 1979 total operating budget as it did in 1971. In one school, although tuition income increased significantly, it contributed a relatively constant percentage of the school's total operating budget throughout the 1970s. Tuition contributed between 8 per cent and 29 per cent of the total operating budgets of the eight schools in 1979, versus contributions ranging from 3 per cent to 14 per cent in 1971.

Among the funding sources available to these medical schools, tuition increases could be implemented rapidly and were comparatively uncomplicated to put into effect. Tuition increases lead to immediate improvements in the school's cash-flow situation. In addition, tuition increases are not subject to the costs associated with other funding sources, such as the promotional expense of a campaign to raise contributions. Furthermore, the schools studied generally implemented tuition increases without raising their contribution to student aid.

Seven of the schools studied are private institutions and charge tuition exceeding those of the state-supported medical schools in their areas. This tuition differential has caused, in some states, an apparent election of students to enroll in public rather than private schools. Private school classes in these states are being filled by qualified out-of-state students. In one of the schools studied, the inability to fill its classes with state residents has prevented the medical school from taking full advantage of state capitation funds available to it. The shift in the proportion of in-state versus non-resident students may, therefore, influence the school's ability to attract future funding from the state. In addition, most of the schools studied expressed concerns that tuition levels could not continue to increase as they did during the 1970s without socio-economic shifts occurring in the medical student population.

Increase practice plan income. Six of the eight schools either restructured existing clinical practice plans or developed new plans to increase the income provided to the school. Efforts to build practice plan revenues had a major impact at four of the schools and a moderate impact at two others. One of the schools made no changes in its ongoing plan, viewing it as sufficiently profitable. The eighth school attempted, throughout the 1970s, to launch a practice plan and only succeeded in doing so in 1980.

The schools that are most reliant on clinical practice income have structured their plans with certain similarities, including:

- A high degree of control exercised by the school over the administration of the plan, which typically includes centralization of the bookkeeping and billing functions and a rigid control over all (or virtually all) practice income generated by the clinical faculty
- Use of a dean's fund, drawn from the net plan income, that can be used at the dean's discretion to fund research and to support new programs or departments generating lesser amounts of practice plan income
- Salary augmentation or payment of incentives to the faculty members who generate increased billings through the plan.

Although the specific provisions of the plan vary among the schools studied, it is clear that practice plan income is a major and controllable funding source for six of the medical schools. In 1972, the faculty practice plans contributed as much as 13 per cent of the operating budget in any of these schools. By 1979, the proportion of the budget drawn from practice plan funds had increased at all of these schools, with one school receiving more than 33 per cent of its total operating funds from its clinical practice plan.

Control salaries/positions. Seven of the eight schools studied implemented salary controls, while four of the seven also exercised controls over the number of faculty and staff positions. For each of these seven schools, controls placed on salaries and/or positions were of moderate importance in improving the financial situation of the school. The one medical school that did not limit its salaries or positions was the institution that received its Financial Distress Grant to maintain its accreditation status; under advisement of the LCME reviewers, it increased its faculty by 11 positions.

Among most of the seven schools that placed controls over their salaries and/or number of positions there are certain similarities, including:

- Clinical faculty members have been encouraged to "earn" additional salary increases through the schools' clinical practice plan.
- Increases for base salaries have generally been less than the increase in the cost of living, averaging between 5 per cent and 7 per cent annually since the mid-1970s.
- Salary increases for the medical schools have been held within the salary guidelines for their respective universities.
- Increases in numbers of positions have been made subject to approval by an established review process within the medical school.

Faculty salary controls and controls of numbers of positions were regarded by a number of the schools studied as temporary measures. The prolonged use of salary controls was felt to increase turnover and to reduce the quality of the faculty. Position controls, unless they mirrored controls over enrollments, could jeopardize accreditation, and were, therefore, viewed as short-term measures by some of the schools.

Change affiliation relationships. Three of the eight medical schools made substantial changes in their relationships or contracts with affiliated hospitals. In each case, restructuring the affiliation agreements proved to be a major factor in improving the school's financial position. In two of these schools, the revised affiliation agreements bring in between 7 per cent and 10 per cent of the schools' operating budgets. In the third case, although the exact percentage of the budget produced by the affiliation arrangement is not quantifiable, the affiliation contracts pay more than 50 per cent of the direct costs of the services provided by the medical school to the affiliated hospitals and actually make possible the teaching programs offered by certain departments of the medical school.

In two of these three cases, restructuring the affiliation arrangements was complicated by the fact that the hospitals served a high proportion of medically indigent patients and were, themselves, experiencing financial difficulties. Modifications in the affiliation agreements therefore, required several years of analysis, negotiation and implementation before the benefits of the changes could be realized. Furthermore, reimbursement options are becoming more restrictive in their policies toward covering the costs of education with patient-care revenues. Changes in affiliation agreements will, therefore, become increasingly limited sources of future revenues.

Relocate/construct facilities. Three of the eight medical schools studied either relocated or constructed facilities. These actions had a major impact at each school. One school relocated from an urban location to a suburban site and, as a result, benefited from improved patient-care facilities at a newly constructed county hospital, established a separate identity from its urban hospital affiliate, and began to serve a region that had no other medical school.

Another of these three schools constructed research facilities and an ambulatory care building and renovated other medical school facilities. These changes enabled the school to maintain or enhance its academic programs and, to a limited extent, to provide additional revenues.

The third school undertook a major construction project, building a hospital and clinic specifically to increase the revenues produced for the medical center and the medical school and to expand the clinical practice plan activities.

Change management structure/personnel. Five of the eight medical schools implemented changes in their management structure or personnel during the 1970s. At one of the schools, changes made in the management structure had a major impact on the financial position of the school, because it laid the foundation for the budgeting and planning processes that were instrumental to the success of the medical school. In two schools, these changes had a moderate impact on the schools financial posture and in two cases the impact was relatively minor.

Structural and personnel changes, however, often have effects that go beyond the schools' operating budgets. In many cases, the managerial and structural changes facilitated other steps that directly increased revenues or reduced costs.

In some of these medical schools, professional managers (rather than individuals with academic backgrounds) were brought in as administrators of the school or the medical centers. This focus on professionalism in management improved the quality of financial management at some of the schools, and helped them achieve many of the objectives that they had set.

Increase state or state-like aid. Seven of the eight schools took steps to secure state or state-like aid or to increase the amount of state assistance they received. Among the eight schools studied, five had never received state or state-like aid at the time they initially applied for financial distress funding. Each of these schools focused its efforts on the need to establish a precedent that its state would provide any financial assistance, rather than concentrating on the absolute amount of money it hoped to receive. Three of these schools were able ultimately to secure state (or state-like) funding as a result of these efforts. The other two schools were unable to change the position of their state legislatures. Although it failed to gain funding from its own state, one of these schools successfully developed programs to secure capitation support from other states.

All three of the schools that already had received state funding at the time they applied for Financial Distress Grants, tried to increase the amount of aid they received from their respective states. Two of these schools succeeded in securing increases in the amount of per-student assistance; the third expanded its enrollment in the early 1970s to take advantage of three available state-aid programs.

Conduct internal cost studies. Cost studies were used by seven of the eight medical schools as diagnostic tools to assess the sources and parameters of their financial difficulties. In two of the schools, the cost studied led to changes in programs and procedures that, in turn, had direct effects on controlling the schools' costs. The cost studies conducted by the other five schools had little direct impact on improving the financial situation of the medical schools, although they were useful diagnostic tools for school administrators. In these cases, the cost studies did not reveal immediate sources of additional revenue or cost reduction possibilities, but did help the schools' administrators assess their situation and focus on the sources and uses of their funds.

Increase contributions. Five of the eight medical schools took steps to increase the amount of gifts and contributions they received. In three of these five cases, fund-raising efforts had a minor impact on the schools' operating budgets. Although the absolute dollar amount raised annually by these schools

through contributions and gifts may have increased dramatically, none of these five schools receives more than 3 per cent of its operating funds from contributions.

As competition increases among schools for contributions and costs of running fund-raising campaigns escalate, school administrators expect contribution/gift income to account for a decreasing proportion of a school's operating budget. In fact, some of the school administrators expressed concerns that fund-raising costs may outpace the revenues generated, making major campaigns a financial burden to the school.

Secure grants. Three of the eight medical schools attempted to obtain grants from outside agencies to cover a portion of their research costs. In these schools, faculty members were encouraged, to varying degrees, to offset their expenditures by securing grants. In two of these three cases, faculty members' research efforts and their success in attaining grants are factored into the salary and tenure-review processes. In all three of these schools, the level of grant support has generally increased despite some slight fluctuations from year to year.

Other actions. In addition to the ten actions discussed individually in the preceding paragraphs, there are ten actions that were taken by only one or two of the schools. In fact, seven of these actions were pursued by individual schools, in response to their unique situations. Overall, these other actions had a relatively moderate or minor effect on the financial position of the medical schools. These actions are, therefore, discussed in more detail in the context of the school-by-school analyses, where the influence of each action on the unique situation of the school is detailed.

V - OTHER CONCLUSIONS AND NEXT STEPS

This final chapter discusses other conclusions derived from this assessment of the Financial Distress Grant Program, and the next steps that should be taken.

OTHER CONCLUSIONS

A number of other conclusions concerning the programmatic and administrative aspects of the Financial Distress Grant Program for medical schools are discussed in the paragraphs that follow.

Programmatic Aspects

The recipients of the Financial Distress Grants have all significantly strengthened their financial positions. As discussed earlier, the grants provided an opportunity for the medical schools to fund substantial portions of their operating deficits during financially difficult periods, while undertaking a series of actions designed to improve their financial situations. In so doing, the program fostered or encouraged a continued self-evaluation by the schools and the development of appropriate action plans. In all eight of the medical schools, the combination of the receipt of the grant and the taking of a series of proposed actions had a positive and beneficial effect. Further, many of the actions have a long-term effect that lasts well beyond the years in which the grants were awarded. For example, expanding practice plan income, putting in place analytical and planning processes and strengthening the caliber of management personnel were of long term benefit to the schools.

The Financial Distress Grant Program appears to have generated a significant impact, disproportionately greater than the limited funding involved (an average of less than \$5 million in total per year from 1972 through 1976, the program's most heavily funded years).

Medical schools are likely to increase tuition to compensate for the decline of federal funding. In the absence of other support from the federal government, it is likely that a series of rapid tuition increases will be made. Tuition increases are easy to enact, require minimal time to take effect, and provide

direct operating income with little additional costs. At some of the schools studied, there still remains a potential for tuition increases to generate additional revenues. Although some of the medical schools cite a possible outflow of students to state schools as a result of their tuitions, the demand for medical school positions continues to be heavy enough to outweigh the rising tuitions.

The awarding of grants having a multi-year time frame would have a number of benefits. The actions taken by the medical schools to improve their financial positions were long-term solutions. As this study has discovered, the effects of these long-term solutions often were not measurable for a number of years after the actions were initiated. Because each Financial Distress Grant was for a single year, the schools committed their resources to pursue long term financial solutions, without knowing whether federal funding would be provided in subsequent years to ensure completion of their plans. A multi-year time frame for the grants would facilitate the schools' execution of their long term financial solutions.

The structure of the program discourages the application for grants by public schools. The state medical schools are typically not in a position to demonstrate a financial distress situation. In fact, many states prohibit their state schools from running operating deficits. By contrast, many of the private medical schools lack state support or other major funding sources, and they are allowed to show a financial deficit.

Administrative Aspects

The title of the program, "Financial Distress," is bothersome to most of the schools. The term "financial distress" has a negative (welfare) connotation that may be inconsistent with the overall intent of the program and with the self-image of the grant recipients. The grant program, in fact, promotes self-help through financial planning and sound management, rather than the use of government welfare funds. The program might more properly be called an "investment in solvency," or some similarly positive title.

The extensive application process is desirable. The data collection and self-analysis required by the Financial Distress Grant application process were, in many cases, helpful to the medical schools. This process provided a structured and thorough mechanism by which the relevant financial and operating data could be collected. Although some of the schools believed that excessive information was collected, many of the school administrators

felt that the grant application process forced them to review their options systematically. Furthermore, the applications might be expanded to require detailed disclosure about the financial situation of the parent university in addition to the information concerning the medical school itself, as the finances of the school and the parent are frequently intertwined.

NEXT STEPS

A number of specific action steps should be taken as a follow-up to this study.

1. This report should be reviewed in detail by the appropriate persons within the Health Resources Administration and be made available to the Health Professions National Advisory Council.
2. A statement of policy should be developed detailing the proper role for the Financial Distress Program within the broad context of aid to medical schools. The development of this statement will require a thorough, analytical assessment of the needs for financial assistance, an identification of the program alternatives to meet these needs, and an analytical evaluation of the strengths and weaknesses of these alternatives.
3. A control group of schools that did not receive Financial Distress Grants should be analyzed and compared with grant recipients. While this study focused on eight of the nine medical schools that did receive financial distress funding, there were an even greater number of schools that applied for, but did not receive, these grants. These schools should be compared with the grant recipients in terms of the actions they took and their success in attaining their stated objectives without the grants.
4. The applicability of this study's conclusions to the other health professions schools should also be explored. Schools of dentistry, pharmacy, osteopathy, podiatry, optometry and veterinary medicine received more than \$30 million of the total \$64 million awarded through the Financial Distress Grant Program. An assessment of the impact of the grants on their activities (similar in scope to this study) would serve to determine whether the conclusions concerning the medical schools also are applicable to the other health professions schools.